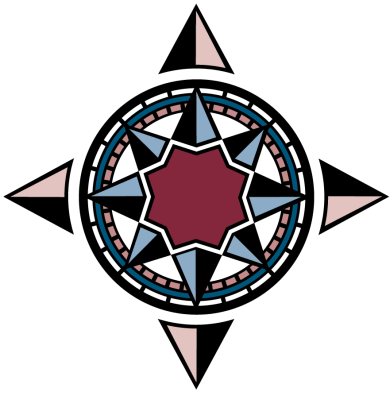

COMMERCIAL MARKET STRATEGIES

CMS Country Assessment:
Prioritized Actions for USAID's Private Sector Family Planning Programs in the Philippines

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LIST OF ACRONYMS/TERMS

BFAD	Bureau of Food and Drugs
CA	Cooperating Agency
CAPS	Commercial and Private Sector Strategies
CDC	Center for Disease Control
CIF	Cost, Insurance, and Freight
CII	Contraceptive Interdependence Initiative
CMS	Commercial Market Strategies
CME	Continuing Medical Education
CSR	Corporate Social Responsibility
CYP	Couple-year Protection
DHS	Demographic and Health Survey
DOH	Department of Health
DSWD	Department of Social Welfare and Development (DSWD)
FCFI	Friendly Care Foundation, Inc.
FP	Family Planning
FPS	Family Planning Survey
FPOP	Family Planning Organization of the Philippines
GNP	Gross National Product
GoP	Government of the Philippines
GR	Gideon Richter
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
IFPMHP	Integrated Family Planning and Maternal Health Program
IMAP	Integrated Midwives Association of the Philippines
IPPF	International Planned Parenthood Federation
IUD	Intra Uterine Device
KfW	Kreditanstalt fur Wiederaufbau (Germany)
LGU	Local Government Unit
MCH	Maternal and Child Health
NEDA	National Economic and Development Authority
NGO	Non-Governmental Organization
OB-GYN	Obstetrician-Gynecologist
OC	Oral Contraceptives
OTC	Over the Counter
PCPD	Philippine Center for Population and Development
PFFP	Philippine Family Planning Program
PIHD	Philippines Institute of Health and Development
POGS	Philippine Obstetrical and Gynecological Society (Foundation)
POPCOM	Commission on Population
PPMP	Philippine Population Management Program
PPP	Purchasing Power Parity
PVO	Private Voluntary Organization
RH	Reproductive Health
SOMARC	Social Marketing for Change
STI	Sexually Transmitted Infection
TA	Technical Assistance

TANGO II	Technical Assistance for the Conduct of Integrated Family Planning and Maternal Health Activities by Philippine Non-Governmental Organizations
TUCP	Trade Union Congress of the Philippines
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
VAT	Value Added Tax
WHO	World Health Organization

I. EXECUTIVE SUMMARY

Context for this Assessment

This assessment provides recommendations for expanding the provision of family planning (FP) through the private sector, with special emphasis on the commercial area. The CMS assessment team focused on contraceptive products, services and providers, policy, and health finance. In addition, the team analyzed the policy environment in the Philippines as it relates to private sector activities regarding family planning. The proposed strategies summarized in Section IX are expected to assist the United States Agency for International Development (USAID) design a plan to increase the private provision of family planning and ensure future contraceptive security in the Philippines.

A major component of USAID population assistance in the Philippines is the procurement of contraceptives for public sector distribution. There has been much talk about the possibility of a phase-out of this donation policy, which might threaten the continuity of services in the public sector. The government of the Philippines appears unlikely to agree to procure its own contraceptives and there is a widely held assumption that it will try to find other donors to replace USAID. Much uncertainty exists, however, regarding the level of support that can be expected from other international donors. To help address the impact of a possible phase-out, USAID has supported the creation of the government's Contraceptive Interdependence Initiative (CII) - a task force in charge of leading discussions on contraceptive self-reliance.

In addition, USAID has supported a number of activities designed to increase the involvement of the private sector in contraceptive supply – including health-care financing, loans to private providers, and social marketing interventions. The private sector provides only 26 percent of married women with modern methods of contraception. This statistic reflects a national preference for seeking family planning services in the public sector. Moreover, a segmentation study by the Policy Project in 1998 indicated that a sizeable portion of middle and high-income Filipinos obtain their supplies in the public sector. This finding prompted discussions about more effectively targeting free products and services and for the private sector to absorb a higher share of the contraceptive market.

Expanded collaboration with the private sector presents inherent advantages that can be leveraged to increase demand for family planning and the sustainable supply of products and services. Among these benefits are existing networks of outlets and providers, powerful market forces fueled by competition and financial incentives, built-in sustainability for profitable activities, and access to the largest financing source in the country – household expenditures. On the other hand, harnessing private sector forces cannot be achieved if promoting contraceptives is incompatible with the strategies of commercial suppliers, as would be the case in the absence of profit. Consequently, expectations for overall growth in the private sector should remain realistic and in line with typical commercial strategies.

Family Planning Environment

The political context of the Philippines has been a determining factor in government policies towards family planning. Progress in reproductive health programs has been encouraged or hindered depending on the influence of the Catholic Church on each administration. Nevertheless, despite a recent shift towards more conservative policies, the public sector is still the largest source of family planning in the Philippines.

The fertility rate in the Philippines remains high at 3.7 children per woman, although this rate varies by region, income level, and education. Contraceptive prevalence reached 49.5 percent in 2001, but modern methods accounted for less than 34 percent. Dissatisfaction with modern methods is reflected in their high discontinuation rates and the difficulties encountered in promoting the use of injectable contraceptives in the late 1990s.

The Contraceptive Market

In addition to reviewing existing market research, the CMS team interviewed key representatives of commercial companies and non-profit organizations that market contraceptives in the Philippines. This activity analyzed market forces and trends, assessed the likely impact of a donation phase-out on demand for commercial brands, and identified opportunities for interventions that foster greater private sector involvement.

Oral contraceptives (OCs) are the most popular method of family planning. They also account for the largest share of contraceptives donated to the Philippine government. The pricing of most commercial OC brands is similar to that of other pharmaceutical products in the Philippines, reportedly among the most expensive in the developing world. In light of easy access to free contraceptives and in the absence of price controls, it is not surprising that most commercial suppliers choose to target (A/B) consumers with high-priced brands, seeking to maximize margins in a segment where volume is limited.

The three largest foreign-based contraceptive producers (Wyeth, Schering, and Organon) participated in the *Couple's Choice* social marketing project managed by Social Marketing for Change (SOMARC) between 1992 and 1998. This project resulted in a substantial increase in sales of their low-priced brands. An analysis of their current marketing strategy, however, indicated that they reverted to a high-price, high-margin strategy after the project.

In spite of this fact, sales of low-priced pills accounted for the largest market growth in volume since 1998. A donation phase-out would most likely increase demand for the lowest priced products on the market – *Trust Pills (*marketed by DKT, a social marketing organization funded by the German government) and *Micropil (*distributed by Pascual, a local manufacturer and distributor). The capacity of these two organizations to absorb large increases in demand, however, as well as DKT's long-term sustainability, has not been assessed.

The private sector market for injectable contraceptives is extremely small. Most of the demand for this method is met by public sector facilities. As overall injectable use is low in the Philippines, opportunities exist for creating demand in the private sector. Pharmacia (the manufacturer of *Depo-Provera)* has expressed interest in developing a partnership that could build sales while limiting the company's exposure to a public backlash. Intra uterine devices (IUDs) have disappeared from the commercial sector, reportedly due to poor sales. Though less

than 4 percent of married women use an IUD, a donation phase-out might threaten access to this method unless affordable products and services are available in the private sector.

Condoms are widely available in urban areas at a variety of prices. Two suppliers (DKT and Philusa, a local distributor) dominate the market. While DKT is responsible for most of the activities that create demand, its ability to meet increases in demand is limited by its reliance on funding from the German bank Kreditanstalt Für Wiederaufbau (KFW). While Philusa isn't hampered by any stock limitations, its board is conservative and unlikely to engage in high-profile condom promotion. As condoms are relatively easy to procure and market, other organizations, such as Friendly Care (a USAID-funded provider of clinic-based services), may be looking to introduce new brands of condoms at commercial off-the-shelf (COTS)-recovery prices. Whether the market can absorb new condom brands and grow in the process depends on the demand created.

A good strategy for expanding private sector provision of contraceptives should follow guidelines that would include following the medical motto of first causing no harm. These would include avoiding cannibalization between sectors and social marketing programs, and avoiding working at cross-purposes with other donors. In addition, changes in supply should follow, not precede changes in demand. The availability of commercial products is bound to swell with any substantial increase in demand, whether it is the result of a demand creation program or a donation phase-out.

Recommended strategies that are likely to have a positive impact on the private sector include:

- publicizing phase-out plans,
- developing partnerships with suppliers on targeted demand creation activities,
- ensuring local capacity for increased supply, and
- expanding access to long-term methods by supporting the training and certifying of midwives as bona fide family planning providers.

Services and Providers

The vast majority of Filipinos obtain family planning services from the public sector, particularly those with low incomes and those who live in rural areas. A key determinant of the provision of family planning services in the private sector is the extent to which patients ask for or express demand for such services. Such demand is unlikely to materialize as long as people see the public sector as the primary provider.

Service providers reflect the same attitudes and beliefs regarding family planning as the general population. Provider associations such as the Philippine Obstetrical and Gynecological Society (POGS) typically do not take an official position on this issue. In contrast, midwives dispense family planning services and products and, with special training, can provide injectable contraception and insert IUDs. The JSI Technical Assistance for the Conduct of Integrated Family Planning and Maternal Health Activities by Philippine Non-Governmental Organizations (TANGO) II project appears to have demonstrated that midwives can run successful commercial clinics, though this project has proved costly and its potential for replication on a large scale is uncertain. Nonetheless, midwives present a potentially expandable strategy for providing

affordable services in the private sector. Contraceptive manufacturers, such as Pharmacia, have recognized their importance.

Consequently, CMS recommends assessing the TANGO II project with special attention to its impact, sustainability, and replication concerns. CMS also suggests investigating the possibility of expanding the network to about 1,000 midwives. At this level, the project could assume a more strategic role in making affordable family planning services available to the general population and in influencing care practices among all midwives. CMS also supports investigating the possibility of collaborating with the professional association that represents 7,000 family physicians throughout the country. These doctors are well positioned in the health delivery system to contribute to the expansion of family planning services.

As with contraceptive products, USAID should exercise caution when funding programs to expand services that might duplicate or compete with the commercial sector. Market and service research is recommended to determine the extent to which service expansion efforts are increasing family planning services beyond those services already being provided by existing private providers, and whether these efforts are serving clients who previously were users of public services.

Work-based initiatives may appear to offer some opportunities to expand family planning services in the private sector. Compliance with existing legislation that stipulates large employers must provide actual health services, however, is erratic at best. Furthermore, work-based clinics that provide family planning often receive donated contraceptives that compete with private sector outlets. Finally, the companies that tend to comply with regulations are poised to be the first beneficiaries of expanded insurance coverage through PhilHealth. Unless private sector services are hard to find, such as in remote work sites, it is hard to justify duplicating services already available at existing private sector facilities.

Health Finance

High rates of out-of-pocket expenditures along with widespread poverty and low levels of insurance coverage indicate that a large portion of health expenditures in the Philippines go towards urgent needs rather than preventive care. Since the early 1990s, much of the responsibility and funding for health, family planning, and other social services have been transferred to local government units (LGUs). As a result, local governments have been the fastest-growing source of health expenditures – ahead of private insurance, managed care, and social insurance.

Expanding insurance coverage is an explicit goal for the Filipino government. While 45 percent of formal private sector and government employees are enrolled in insurance plans, most informal workers and indigents have no coverage. Efforts to expand coverage to these groups, however, are underway. For example, PhilHealth, the national health insurance system is hoping to enroll 100 percent of indigents by 2010. Public and private insurance companies acknowledge that there is little or no coverage for family planning services or products, with the exception of female sterilization.

Strategies in the current health finance reform that can benefit the private sector include:

- encouraging PhilHealth to expand its benefits coverage of family planning services;

- supporting the expansion of coverage to informal sector workers and indigent populations;
- identifying alternative financing for services not covered by PhilHealth;
- using PhilHealth coverage expansion to develop demand for private sector services; and
- providing PhilHealth with select technical assistance to address operational and growth challenges.

Policy

CMS's assessment revealed some encouraging factors for private sector expansion, such as a strong capacity for product and service provision, and expanding service coverage by PhilHealth. On the other hand, strong opposition from the Church, insufficient information about government and donor policies, and inadequate representation in discussions about family planning contribute to a lack of initiative from the private sector. CMS conducted an analysis of policy initiatives to identify those most likely to encourage or discourage private sector growth. Policies that should facilitate private sector involvement include those that relax restrictions on service provision, create demand, and provide financing for private providers through social health insurance expansion. Ineffective policies include untargeted provision of free and subsidized products and services, initiatives that have a prescriptive or coercive component, and those that incite controversy.

Market segmentation encourages the public sector to focus on serving low income and hard-to-reach clients, while the private sector is encouraged to meet the needs of clients with the ability to pay. Implementation of such an approach in the Philippines will require more refined information, dialogue and advocacy among stakeholders, and concerted action by the government, private sector, nongovernmental organizations (NGOs), and others.

CMS recommends establishing a private sector-led coalition for reproductive health to provide a forum for discussing issues and developing common strategies amongst stakeholders. The coalition also is expected to afford much-needed representation for private sector suppliers and service providers in policy discussions regarding family planning, particularly in the event of a donation phase-out. In addition, CMS suggests additional analysis on market segmentation to determine the impact of a USAID phase-out and pilot-testing interventions that can shift some users from the public to the private sector. These methods may include user fees or voluntary donations at public facilities and targeted allocation of public subsidies according to clinic location or other criteria. An analysis of policy initiatives being contemplated is provided, emphasizing those that are consistent with private sector expansion and those that may discourage it.

Recommendations

The strategies suggested by CMS address the present family planning climate and the possibility of a donation phase-out. For the current situation, CMS provides a set of recommendations intended to increase private provision of family planning. In the case of a phase-out, CMS recognizes that increasing the role of the private sector may not be sufficient to ensure contraceptive security. Therefore, the second set of recommendations includes additional actions.

Strategies to increase private provision of family planning focus on demand creation programs and ensuring that supply can meet any increase in demand through a variety of activities, including partnerships with local and international suppliers. In addition, CMS provides recommendations for improving the current environment to allow these changes to occur. Strategies to ensure contraceptive security acknowledge that a percentage of users of free products and services may not be able to afford commercial alternatives. CMS recommends designing a specific phase-out plan using segmentation information and discussing this plan with, and to gain support from, all stakeholders.

Summary of Recommendations for Increasing the Private Provision of Family Planning in the Philippines

Increasing Demand

1. Support demand creation activities that increase demand for private sector products and services.

2. Support PhilHealth plans to expand its enrolled population and its coverage of select primary care services, such as MCH and family planning (especially those delivered by private sector providers).

3. Explore partnering with Pharmacia to increase demand for injectables in the private sector.

4. Assess the potential contribution of a more extensive medical detailing campaign (beyond just injectables) that would be directed at best-placed pharmacists and private providers.

5. Where insurance-reimbursed care is available, refocus employer-based strategies to emphasize information and referral rather than creating service clinics. Approach labor organizations to discuss collaboration in these same health and family planning initiatives.

Increasing Supply

6. Document the impact and lessons learned from the TANGO midwives project; reconsider possible revamping and scaling up of this initiative, as well as other mechanisms for working with private midwives to expand family planning products and services to low- and middle-income clients.

7. Conduct research on public/private utilization patterns of contraceptive users.

8. Explore partnership opportunities with local manufacturers of oral contraceptives, as well as assess the quality of these products to verify their promotion.

9. Work with existing professional associations to promote family planning provision and quality standards through existing approaches to professional development.

Improving the Environment for Private Sector Provision

11. Facilitate the establishment of a private sector-led coalition for reproductive health.

12. Review policy initiatives and pursue those that foster private sector provision.

13. Assess PhilHealth's technical assistance needs and consider the need for increased support in select operational facets that will allow it to more rapidly expand its coverage.

Ensuring Contraceptive Security

14. If it so intends to phase-out procuring contraceptives in the Philippines, USAID should develop a plan, commit to it, and share this plan with all interested parties, including the private sector. As described in this report, such a phase-out might be best done one method at a time.

15. Assess DKT's capacity to absorb a large increase in demand for low-price OCs and condoms.

16. Assess the capacity of local manufacturers to meet increases in demand.

17. Revisit and supplement the market segmentation analysis to determine the impact of phasing out USAID-donated contraceptives.

18. Support more pilot testing of approaches for shifting more affluent family planning clients from public to private sector.

19. Investigate alternatives for ensuring a supply of IUDs. One possibility may be to reintroduce commercial supplies of this method. Do not phase out supply of IUDs until an affordable alternative exists for low-income people.

II. INTRODUCTION

The Commercial Market Strategies (CMS) project is a five-year contract implemented under the Commercial and Private Sector Strategies (CAPS) Results Package of the United States Agency for International Development's (USAID) Center for Population, Health, and Nutrition (G/PHN/POP). As the flagship project of CAPS, CMS aims to increase the use of family planning and related health products and services through the private and commercial sector. The CMS project's main program areas include: social marketing, private provider networks, health financing alternatives, partnerships with pharmaceuticals, corporate social responsibility, Summa Foundation loans, nongovernmental organization (NGO) sustainability, and policy analysis and intervention that enables the private commercial sector to better participate in meeting national health and family planning goals.

To fulfill its mandate, CMS conducts technical assessments in selected countries to evaluate the conditions and markets for private sector family planning and related health care. Based on these reviews, the assessments recommend program interventions for the selected country. This report is an assessment of the environment for private sector family planning and reproductive health service delivery in the Philippines.

This assessment provides recommendations for expanding private sector family planning (with a specific emphasis on the commercial sector) and examines the prospects for achieving contraceptive security. In the Scope of Work agreed upon with USAID, CMS was asked to:

- look at ways to expand the commercial sector's activities so that it better complements the program efforts provided by the public and private nonprofit sectors; and

- recommend how the commercial sector might replace or fill gaps in services previously provided by the public sector.

The complete Scope of Work, as agreed upon with USAID/Philippines, is included as Appendix 1.

This assessment report is based on a two-week visit by a three-person CMS core staff team consisting of:

- Craig Carlson (Regional Manager for Asia / Near East and team leader)
- Francoise Armand (Technical Advisor for Social Marketing)
- Susan Scribner (Technical Advisor for Policy)

Providing additional support to the team were Diana Escueta in Washington, DC and John Dioquino in Manila. The team conducted an extensive document review and met with representatives of numerous organizations during its travel to Manila from February 18 – March 1, 2002. These organizations included:

- USAID/Philippines and other donors
- Government agencies
- Local cooperating agencies
- Service provider institutions
- Pharmaceutical manufacturers and distributors
- Health care institutions

A complete list of contacts is included as Appendix 2. A list of documents that were reviewed for this assessment is included as Appendix 3. Prior to their departure, the team met with officials from USAID to debrief them on their preliminary findings and recommendations. This report discusses those findings and recommendations in greater detail.

III. WHY WORK WITH THE PRIVATE SECTOR IN THE PHILIPPINES?

As the team was asked to assess opportunities for expanding the role of the private sector in providing family planning products and services, this section clarifies the benefits and the drawbacks of working with the private sector in the Philippines.

A. Benefits of the private sector

- A primary reason to expand the family planning provision in the private sector is its **existing capacity**. The Philippines has a substantial number of private providers, including obstetrician-gynecologists (Ob-Gyns), family physicians, and midwives, as well as extensive networks for commercial distribution and at least one local contraceptive manufacturer.

- If the private sector considers an activity (such as the provision of general family planning or of specific methods) – a good business opportunity, it is likely to be replicated. These activities can **harness the market forces** of the private sector and tap into private resources and capacity. The incentive for widespread replication, therefore, would come from the desire of private sector providers to be competitive, rather than from direct donor interventions. Expansion would not require the direct building of clinics, training of providers, or supplying of pharmacies.

- Similarly, if private providers see family planning as a good business opportunity, it will be offered in a **sustainable** manner. Continued provision will not depend on donor assistance.

- The primary source of **financing** for contraceptives in the private sector are households. Compared with purchases for health needs, household expenditures for family planning are still relatively small. Furthermore, many clients with the ability to pay for contraceptives get their products from the public sector because they are free. Increasing the provision of family planning through the private sector will tap into households as a source of financing.

B. Limitations of the private sector

- The commercial sector, including contraceptive manufacturers and for-profit providers, operates on a **profit motive**. Its definition of a good business opportunity generally implies a profitable endeavor. Hence, commercial providers are unlikely to significantly expand their provision of family planning if it is not profitable, regardless of the motivation for corporate social responsibility (CSR). In the conservative environment of the Philippines, CSR initiatives are not likely to focus on family planning or reproductive health, as they do not necessarily improve the company's image.

- Because of the profit motive, the commercial sector is also unlikely to target its products and services to low-income or hard-to-reach consumers. Therefore, they have **limited capacity to serve poor or rural clients**.

To maximize the advantages of engaging the private sector in family planning, while taking into account its limitations, the following conclusions need to be considered:

1) Engaging the commercial sector requires approaches that recognize the incentives created by profit and competition.

2) In the absence of changes in the market and environment, the commercial sector will continue to serve middle- and upper-income people.

3) Expectations for the contributing role of the private sector should be realistic.

IV. COUNTRY BACKGROUND

The Philippines is an archipelago of over 7,000 islands off the southeast coast of the Asian mainland. A census taken in 2000 estimates the country's population to be 76.5 million people – one of the most populous nations in the region and among USAID-assisted countries. With a per capita GNP (PPP[1]) of $3,725, the World Bank classifies the Philippines as a lower middle-income country.[2] The population's annual growth rate of 2.4 percent, however, is deemed high and outpaces the country's overall weak economic performance, which averaged 3 percent annual growth in the last 30 years.

The Philippines went through periods of political upheaval in the last few decades while seeking to strengthen its democratic systems and institutions. Likewise, the economy has had a mixed history. Mirroring the country's economic performance and political history, support for family planning in the Philippines has varied with each presidential administration. Overall, political support for family planning remains weak; an influential Catholic Church and a deeply pronatalist culture continue to challenge the country's family planning program.

A. The Government's Family Planning Program

During the Marcos administration (1968 to 1986), population issues were a priority. The government's desire to increase its attention to population and family planning programs was evidenced by the creation of the Commission on Population (POPCOM) as part of the Office of the President. POPCOM was created in 1969 as the central coordinating and policy-making agency of the Philippine government on population issues and served as the launching ground for the Philippine Family Planning Program (PFFP) in 1970.

Up until the mid-1980s, the PFFP had two components – family planning and the population-development relationship. Two of the critical shifts in programming included:

1. The transfer of the family planning component to the Department of Health (DOH) in 1988, which later integrated family planning into its maternal and child health program. The population-development component remained the responsibility of POPCOM, which focused on policy coordination, advocacy, and evaluation.

2. The passage of the Local Government Code in 1991, which devolved the delivery of government health services (including family planning) to local government units (LGUs).

In addition to these shifts, POPCOM's mother agency was switched, first from the Office of the President to the Department of Social Welfare and Development (DSWD) and then to the National Economic and Development Authority (NEDA) where POPCOM now resides.

During the Aquino administration (1986 to 1992), progress in developing family planning programs was muted due to the strong influence of the church and its pivotal role in ousting

[1] Purchasing Power Parity (PPP) reflects international differences in relative prices by converting GNP per capita into international dollars.

[2] *2000 World Development Indicators* (The World Bank)

Marcos and propelling Aquino to the presidency. The Ramos administration (1992 to 1998) attempted to revive the government's family planning program. Under Ramos, the PFFP became known as the Philippine Population Management Program (PPMP), adopting the population-resources-environment framework. The Catholic Church, however, responded with an even greater and more vociferous opposition to the government's family planning initiatives. The Estrada (1998 to 2001) and Macapagal-Arroyo (2001 to present) administrations that followed have adopted a more conservative stance regarding the implementation of family planning programs to appease the church.

In recent years, the PPMP has shifted its policy from the more divisive context of achieving demographic goals towards a client-centered recognition that family planning is part of the human development agenda. The current administration places significant emphasis on alleviating poverty and views the family planning program as part of that agenda.

The public sector is the dominant source of supplies for family planning in the Philippines. The most recent Family Planning Survey (FPS) shows that 72.8 percent of married women obtain contraceptive products or services from the public sector, where they are provided for free or for a small donation. Table 1 shows the distribution of modern methods by public source.

Table 1. Percent Distribution of Modern Method Users by Public Source (2001)

Total Public Sector	**72.8**
Government Hospital	23.4
Rural Health Unit	24.8
Barangay Health Station	22.2
Barangay Officer / Health Worker	2.4

Source: Family Planning Survey, 2001 (National Statistics Office)

B. General Family Planning Indicators

Though fertility and population growth rates have fallen in the last few decades, the rates of decline have not been as steep as might be expected. Despite substantial declines in fertility rates in much of Southeast Asia, the Philippines' rate remains high at 3.7 children per woman compared to its neighbors' (average of 2.1 for East Asia and Pacific [3]). According to the 1998 Demographic and Healthy Survey (DHS) report, other notable trends [4] include

- Fertility levels vary greatly:

  - between urban (3.0) and rural (4.7) areas

  - by region (from 2.5 in Metro Manila to 5.9 in Eastern Visayas)

[3] *2001 World Development Indicators*, (The World Bank)

[4] *National Demographic Survey 1998*, (Macro International)

- according to women's education (5.0 for women with no formal education and 2.9 for women with at least some college education)

- Fertility rates have not fallen more rapidly in recent years due to:

  - a desire for moderately large families (3.2 children)

  - higher rates of unplanned pregnancies (45 percent of births)

- On the other hand, some of the trends that have contributed to the decline in fertility rates include:

  - a pattern of late marriage and childbearing (median age 22 and 23, respectively)

  - slightly higher proportions of women in the population who never give birth (9-10 percent of women).

There has been a modest but gradual increase in contraceptive use over the years. Overall, contraceptive use among married women increased from 40 percent in 1993 to 47 percent in 1998. Traditional methods always have accounted for a large proportion of that use; female sterilization remained the most widely used modern method. Table 2 summarizes the changes in contraceptive prevalence during the last three survey periods.

Table 2. Contraceptive Prevalence, by Method (percent)

	Pill	IUD	Injection	Condom	Female Sterilization	Modern Methods	Trad'l Methods	Any Method
1993 DHS	8.5	3.0	0.1	1.0	11.9	24.9	15.1	40.0
1998 DHS	9.9	3.7	2.4	1.6	10.3	28.2	18.3	46.5
2001 FPS	14.1	3.3	2.8	1.7	10.5	33.1	16.4	49.5

Unmet need declined in the 1998 DHS survey; only one-fifth of married women in the Philippines have an unmet need for family planning as opposed to one-fourth of women in the 1993 survey.

The DHS report found that contraceptive discontinuation (35 percent in 1993 and 41 percent in 1998) is one of the major challenges. Another problem (cited in other studies) is that little information is available on the involvement of men regarding reproductive health care knowledge and decision-making. Consequently, an obstacle may exist that is not being sufficiently addressed.

C. The Role of the Private Sector

The private sector's role in providing family planning services and products in the Philippines is relatively small. As mentioned earlier, the public sector is still the dominant source of supply.

The most recent surveys show that the private sector provides only 26 percent of married women with modern contraceptives. Table 3 shows the breakdown by source for each contraceptive method for the last three survey periods.

Table 3. Source of Supply for Modern Contraceptives

	Public Sector			Private Sector[5]		
METHOD	**1993 DHS**	**1998 DHS**	**2001 FPS**	**1993 DHS**	**1998 DHS**	**2001 FPS**
Pill	73.4	76.4	71.5	25.6	23.6	28.3
IUD	78.8	82.4	80.8	20.1	17.0	18.7
Injection	17.9	92.0	92.1	82.1	8.0	6.8
Condom	55.6	41.4	43.5	43.3	58.6	55
Female Sterilization	70.4	65.6	71.7	29.3	33.8	27.9
Male Sterilization	56.6	47.1	76.2	35.2	49.0	23.7
TOTAL	**71.4**	**72.0**	**72.8**	**27.7**	**27.7**	**26.8**

Several studies have been done locally through USAID programs that explore the private sector market for family planning services in greater detail. One such survey conducted in 1996[6] revealed that consumers had an equal preference for private doctors/clinics versus public health centers for basic health care services (46 percent for private and 42 percent for public). But for family planning services, consumers preferred the public sector to the private sector (53 percent for public and 25 percent for private).

A separate market segmentation analysis study also showed a marked preference for the public sector for family planning.[7] The study found that government hospitals and Barangay Health Stations dominate the family planning market (59 percent), followed by private hospitals (17 percent), and semi-private centers and Rural Health Units (13 percent). The primary reason for using the public health facilities, according to 90 percent of consumers, is that services are free

[5] Includes Private Medical and Other Private categories

[6] *Consumer Source on Preferred Source of Basic Health Care and Family Planning Services*, (PROFIT, Deloitte Touche Tohmatsu International, Philippines, March 1996).

[7] Alano, Bienvenido P., Eliseo A. de Guzman, Corazon M. Raymundo and Dr. Willliam Winfrey, *Family Planning Use in the Philippines: Market Segmentation Study* (The Policy Project, The Futures Group International, Manila, February 1998).

or inexpensive. The high consultation costs of private clinics discourage consumers from using them.

The same study also shows that the ability and willingness to pay did not correlate directly with the choice of public and private sector services. A number of consumers from income segments who were apparently able to pay for services still chose to obtain the government services. According to this study, the potential for private sector growth is significant; if all public sector middle- and high-income users were shifted to the private sector, that market could potentially double from 15 to 31 percent.

There is also a substantial use of subsidized socially marketed products (i.e. condoms and pills), which are included in the private sector by the DHS. These contraceptives are financed by the German development bank Kreditanstalt Für Wiederaufbau (KFW), marketed by DKT, and offered at highly subsidized prices. The remaining private sector share is small and comprises mainly A and B class clients. Due to the relative abundance of free and subsidized products, commercial manufacturers assume that C class clients have limited ability to pay, nor the willingness to do so. The international manufacturers, therefore, are satisfied serving their high-income clients and have little interest in offering lower priced products.

From the provider perspective, a separate survey conducted in 1996[8] among private providers found that midwives had a greater potential for expanding their family planning clientele than doctors. Fewer midwives offered family planning services than physicians, but those who did served relatively more FP clients. Midwives were less restrained by religious beliefs and expressed a greater interest in training and marketing FP services and products.

D. USAID Programs

Private Sector Programs

As the predominant family planning donor in the Philippines, USAID views the country's population growth as a "significant problem," limiting the country's progress in revitalizing its economy and placing an already fragile environment under growing pressure.[9] Recently USAID has refocused its family planning and health program to include building the capacity of the private sector and local governments (due to the devolution of health services) to deliver family planning and health services while continuing to focus on national-level policy and advocacy issues.

USAID has implemented several activities and programs during the last decade that are aimed at increasing the private sector's involvement in providing family planning products and services. Some of these past activities are described below; some of the more relevant findings of these programs are cited throughout this report.

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[8] *Attitudes and Practice Survey Among Health Professionals in the Private Sector* (PROFIT, Deloitte Touche Tohmatsu, and SOMARC/The Futures Group International, January 1996).

[9] *Revitalizing the Economy and Transforming Governance to Accelerate Sustainable Growth: USAID/Philippines Strategy for FY 2000 – FY 2004* (USAID/Philippines, October 1, 1999).

- The ENTERPRISE project conducted several studies and implemented a variety of program activities in the Philippines. A feasibility study on franchising existing clinics led to an on-going program to provide technical assistance to the Philippine NGO Council to strengthen its management and increase its income generating opportunities through clinic franchising. ENTERPRISE also conducted workplace-based programs with two large companies: Benguet Gold Operations and Matling Industrial & Commercial Corporation. Additionally, it successfully worked with the Philippine Center for Population and Development (PCPD), a local NGO, to develop responsible parenthood programs in a multitude of industrial companies.

- Social Marketing for Change (SOMARC) launched a campaign in 1993 in collaboration with three pill manufacturers. It involved each manufacturer's commitment to maintain a retail price ceiling, determined by research to be affordable by middle-income groups. In 1994, the injectable, Depo-Provera was launched in the Philippines, with SOMARC providing media and training support. The SOMARC program ended in 1998.

- Promoting Financial Investments and Transfers (PROFIT) was designed to use financial investments to encourage private and commercial sector entities to participate in the family planning market. From 1994 to 1996, PROFIT implemented two pilot projects in the Philippines: (1) the development and rollout of a low-cost health care plan that included reproductive health care in collaboration with a local major health maintenance organization (HMO); and (2) a loan fund for private doctors to start new or improve existing private practices, in collaboration with a local micro-lending institution.

- Prior to this current commercial sector assessment, in 2000 CMS provided technical assistance to the USAID Mission by assessing the prospects for sustainability of the Friendly Care Foundation, the midwife-run clinic franchise of the Technical Assistance for the Conduct of Integrated Family Planning and Maternal Health Activities by Philippine Non-Governmental Organizations (TANGO) II project, and the prospects for phasing out USAID contraceptive procurement.

USAID's health and population activities in the Philippines are organized around Strategic Objective 3: "Reduced Fertility and Improved Mother and Child Health" and the incorporation into this objective of Special Objective 1: "Threat of HIV/AIDS and Other Selected Infectious Diseases Reduced".

USAID implements its program activities in the Philippines through the DOH, POPCOM, local governments, and NGOs that are involved in national family planning, child survival, and national health insurance programs (including local NGOs, US private voluntary organizations (PVOs), and private commercial sector entities). Table 4 describes the activities and sector focus of the some of the major contractors in the Philippines:

Table 4. Cooperating Agencies working in the Philippines

Contractor	Public Sector	Private Sector
Engender Health (formerly AVSC)	Works with hospitals to provide quality sterilization services	Trains doctors to provide quality voluntary sterilization
Friendly Care Foundation, Inc.		Delivers affordable reproductive health care to lower- and lower-

Contractor	Public Sector	Private Sector
		middle income Filipinos
John Hopkins University / School of Public Health	TA to DOH and local hospitals to promote quality health services	TA to Friendly Care Foundation
JSI Research & Training Institute, Inc.	Provides TA to DOH on contraceptive logistics management	Delivers FP/MCH services through midwife-owned clinics
Management Sciences for Health (MSH)	TA to DOH and local hospitals to promote quality health services and develop models for local procurement and distribution of drugs; TA to PhilHealth[10] to expand and revise coverage of social health insurance; and TA to local governments to develop models for health administration.	
Population Council	Conducts operations research to assist DOH, local governments, and research institutions	
The Futures Group (TFGI) / POLICY Project	Provides TA to enhance environment for public sector to target services to the poor	Provides TA to enhance environment for private sector to increase provision of services and products.

Some of the key private and commercial sector programs are:

- The Friendly Care Foundation, Inc. (FCFI) is a private-sector foundation that aims to provide family planning and health services to lower-middle- and middle-income groups on a financially sustainable basis. Supporters hope that by demonstrating a financially-sustainable model for providing family planning and health services to the poor, other private sector providers will follow the Friendly Care example and that public resources can then be redirected toward the poorest sector of the population.

- JSI Research & Training Institute, Inc. is implementing the TANGO II Project. Its goal is to increase the availability of family planning services in the private sector by expanding the number of midwife-owned clinics that provide FP and basic MCH services. TANGO II's major innovation is a private sector franchise model for midwife clinics – the Well Family Midwife Clinics, which provide FP and MCH services for profit.

[10] The Philippine Health Insurance Corporation (PhilHealth) assumed the responsibility of administering the former Medicare program for government and private sector employees, with its transfer from the Government Service Insurance System (Oct. 1997) and Social Security System (April 1998). This transfer also included the turnover of the nation's health insurance funds and funds contributed by local governments, for the implementation of the national health insurance plan (NHIP) in 1998.

- The POLICY Project, being implemented by The Futures Group, has conducted activities to strengthen the capacity of national government agencies in formulating information-based population and FP/RH policies and programs. POLICY's activities are focused on advocacy and implementing population policies that aim to increase resources for services in the public and private sectors and to enhance private sector participation in the provision of services.

- EngenderHealth (formerly AVSC) works with the DOH's Integrated Family Planning and Maternal Health Program (IFPMHP) funded by USAID. Recently, EngenderHealth has been working with the private sector to provide high-quality, accessible reproductive health services.

Donation of Commodities

A major component of USAID population assistance is the procurement of contraceptives for public sector distribution. In the Philippines, oral contraceptives (OCs) comprise the larger share of that procurement. Tables 5a and 5b show the trends in USAID's contraceptive donations to the Philippines during the last decade.

In recent years, there has been much discussion about the possibilities for phasing-out the donation of contraceptives for several countries, including the Philippines. To address the impact of such a phase-out on the continuity of services in the public sector, USAID has provided assistance to the government's Contraceptive Interdependence Initiative (CII), a task force instituted in early 2000 to lead the discussions for achieving contraceptive self-reliance or security. This effort has resulted in the DOH budgeting, for the first time, the procurement of approximately $1.7 million worth of OCs. As of publication, however, it appears unlikely that the government will approve this procurement.

Table 5a. USAID-donated Contraceptives (Cost in $ 000)

Year	OC (Lo-Gentrol)	Condom	IUD	Injectable (DMPA)	TOTAL
1992	2,474	1,604	218		4,296
1993	3,214	924	764		4,902
1994	3,997	1,244	258		5,499
1995	1,462	774	108		2,344
1996	1,973	275			2,248
1997	486	197	83		767
1998	1,805	301	225	1,251	3,582
1999	2,448	465	138	2,609	5,660

2000	2,861	755	224	1,189	5,030
2001	4,787	500	107		5,394

Table 5.b USAID-donated Contraceptives (thousand units)

Year	OC (Lo-Gentrol) (cycles)	Condom (pieces)	IUD (pieces)	Injectable (DMPA) (vials)
1992	14,986	24,042	184	
1993	18,659	17,520	433	
1994	22,854	23,574	225	
1995	7,735	15,066	90	
1996	9,935	5,310		
1997	2,377	3,570	64	
1998	8,725	5,310	161	1,287
1999	11,219	8,880	88	2,679
2000	12,944	11,934	153	1,214
2001	19,486	7,314	68	

Source: OPHN / USAID Philippines

Other Related Health Programs

Though AIDS is a major problem in other countries in Southeast Asia (most notably Thailand and Cambodia), the Philippines largely has been spared a widespread epidemic, despite an active sex industry and a sizable population of injecting drug users. The successful result so far has been attributed to the nation's prevention and control program, which is funded mainly by USAID.

Much work still needs to be done to fight other infectious diseases. Tuberculosis, including multi-drug resistant strains of the disease, is growing rapidly; the Philippines already has one of the highest prevalence rates of tuberculosis in the world. Dengue cases have risen rapidly in recent years and represent a major health threat, particularly to children. Malaria is also resurgent in areas of the country.

USAID will continue its successful HIV/AIDS surveillance and education activities among high-risk behavior populations in eight large cities. USAID also will work with the DOH to establish surveillance and community mobilization systems covering tuberculosis, dengue fever,

and malaria, with assistance to be provided by the U.S. Centers for Disease Control (CDC). The DOH is establishing its own CDC-type of organization, the Philippines Institute of Health and Development (PIHD). USAID expects that funding will end as the PIHD becomes fully operational.

E. Conclusions

The role of the private sector in the provision of family planning services and products in the Philippines is still relatively weak. There are several factors that need to be addressed in seeking to work more effectively with the private sector. Foremost is the lack of political support and the strong opposition from the Catholic Church, which creates an unsupportive environment for private sector family planning. Many of the private and commercial firms, manufacturers, and other institutions that the team met with during this trip are led or managed by individuals with conservative views that influence the entire organization's stance on family planning. For the few individuals and organizations that do support family planning, they may perceive that any efforts to expand their role would be unproductive as long as the overall environment remains unsupportive.

Another factor is the uncertainty of USAID's phase-out of contraceptive commodities. The private sector, particularly the commercial contraceptive manufacturers, is aware that USAID is considering phasing-out its contraceptive donations and it recognizes that a change in the donation policy would affect the contraceptive market significantly. It is uncertainties about when a phase-out would take place, however, and what products would be affected that has caused organizations in the private sector to be uncertain about how to plan for or respond to a phase-out. Similarly there is a widely held assumption that the government of the Philippines would try to find another donor to supply contraceptives to the public sector. Again, the private sector is unsure if another donor would get involved, if those donations would fully replace or even exceed USAID contributions to meet projected increases in demand. The national government's willingness to procure contraceptives appears unlikely during the present administration and local government willingness and capacity is unknown.

In addition to the uncertainties in the supply environment, the private sector may not have enough information about clients in the public sector that currently obtain free products. Such information may exist but may not be readily available to the private sector, making it difficult for it to predict the demand response, should the public sector experience significant shortages. Despite a vague interest in impending changes to the market, the private sector is unlikely to change its strategy or make new investments without better information on which to base such a decision.

In conclusion, efforts to expand the role of the private sector in family planning should involve

- increasing the dialogue among the major stakeholders, including the private sector, while taking into consideration the prevailing environment for family planning, and
- providing the private sector with information regarding the supply environment and existing market.

V. THE CONTRACEPTIVE MARKET

A. Sources of Contraceptive Products

The public sector is the main supplier of contraceptive products in the Philippines. The 2001 FPS[11] indicates that nearly 73 percent of family planning clients obtain contraceptive supplies from public health facilities. The availability of contraceptives at these facilities would likely be impacted by a discontinuation of USAID commodity donations to the Philippines. While no time frame has been announced for a phase-out, a ceiling for donations has been set at $3 million for the next two years, which may result in a product shortfall at public health facilities.

While other countries have experienced phase-outs in the past (such as Turkey and Mexico), they have been willing to switch to a commodities procurement strategy, thereby ensuring continued stocking of contraceptives at public sector facilities. It appears unlikely that the Philippine government will agree to procure contraceptives, however, in part because of the controversial nature of the family planning program. As a result, a donation phase-out will most certainly switch some of the burden of paying for contraceptives to households. While it may not meet the needs of all current users, ensuring the availability of affordable contraceptives in commercial outlets can substantially reduce the reliance on free ones in the Philippines.

A segmentation study conducted by the POLICY project in 1996 revealed that public sector use increases significantly for low-income users and for users who live in rural areas. The study also noted, however, that a sizeable portion of public sector users comes from middle- to high-income groups. This fact suggests that some might be able to afford commercial brands, which makes them a potential target group for the private sector. Therefore, an important task for the CMS team was to assess whether the private sector has any interest in actively recruiting these potential customers.

The CMS team reviewed prior private sector assessments and interviewed various representatives from the private sector contraceptive industry in an effort to answer the following questions:

- *What range of products and prices are available in the private sector?*
- *Who are the key players in the private contraceptive market?*
- *What strategies are contraceptive suppliers pursuing in terms of target population, product positioning, and demand creation activities?*
- *What perception do they have of current public sector users and do they consider them a potential target group for their products?*
- *What is the likely impact a contraceptive phase-out would have on demand and supply in the private sector?*
- *Is there any support in the private sector for public/private partnerships to increase their contribution to contraceptive supply in the Philippines?*

[11] *Family Planning Survey* (National Statistics Office of the Philippines, 2001)

B. The Private Contraceptive Market

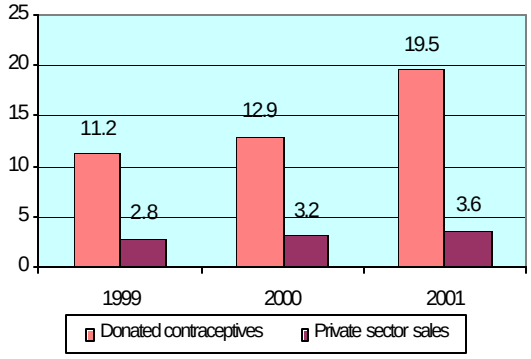
Contraceptive products sold in the Philippines include condoms and hormonal contraceptives, such as pills and injectables. These two classes of products exist in different regulatory and business environments. As consumer goods sold over the counter, condoms face few distribution and advertising restrictions. In contrast, a doctor must prescribe pharmaceutical or ethical contraceptives[12] and laws prohibit brand advertising for this class of product. In addition, trained providers must administer injectables, which further restricts their availability and affordability.

Prevailing business practices also affect contraceptives in different ways. For example, condoms typically are promoted directly to the consumer, priced competitively, and widely distributed in a variety of outlets. Oral and injectable contraceptives, however, are priced according to the same practices that rule pharmaceutical products and are typically marketed to providers rather than the end users. Because of these significant contextual differences, the contraceptive market is best analyzed one method at a time.

Oral Contraceptives

Oral contraceptives are the most popular modern family planning method. In 2001, 14 percent of married Filipino women chose this method. They have been widely available for free at public health centers for the past decade, which undoubtedly has contributed to their popularity.

Chart 2: Distribution of Oral Contraceptives (in millions of cycles)



According to the 2001 Family Planning Survey[13], 71.5 percent of married women who use oral contraceptives obtained them from the public sector. The remainder purchased pills in the private sector – essentially pharmacies. These figures are in line with the current split between commodities distributed through the public sector and pills sold in the private sector (see chart 2). (It is important to note that 33 percent of pills sold through the private sector are distributed by a subsidized program.)

Suppliers, Brands, and Prices

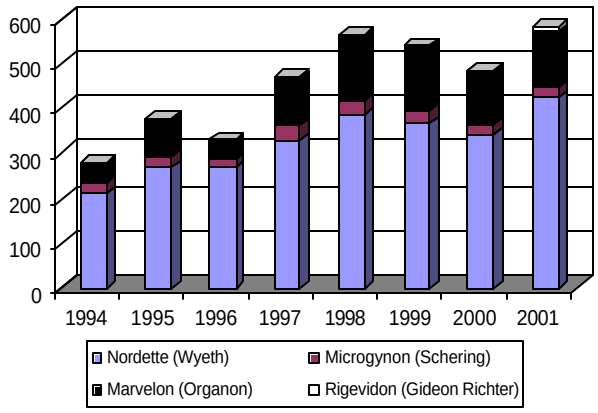
The leading contraceptive suppliers in the Philippines are foreign-based pharmaceutical companies with large product portfolios. Wyeth is the third largest pharmaceutical company in the country and a leader in the contraceptive market, in terms of units sold and revenue. Contraceptives account for less than 5 percent of Wyeth's overall turnover versus 14.5 percent for Schering, the second largest commercial supplier, and 6.2 percent for Organon, the third

[12] In practice, once the initial prescription has been filled, most pharmacies will sell refills without requiring a new prescription.

[13] *Family Planning Survey* (National Statistics Office of the Philippines, 2001)

largest[14]. Wyeth is also the only supplier of oral contraceptives to USAID, although these sales are realized in the United States. These three commercial leaders were approached by the SOMARC project in 1992 to participate in a social marketing program aiming to increase the provision of contraceptives through the private sector. Three products—*Nordette, Microgynon,* and *Marvelon*—were positioned for lower income consumers at a reduced price. SOMARC activities included a mass media campaign under the *Couple's Choice* logo, improved detailing, and a grass-roots public relations campaign. Sales of the three brands doubled between 1992 and 1998, although Organon had withdrawn *Marvelon* from the program by 1996. In the same period of time, the overall market only grew 55 percent.

Chart 3. Evolution of SOMARC brands (thousand cycles)



The companies that participated in the SOMARC social marketing have grown their business substantially in the past five years (see chart 3). Gideon Richter, another foreign-based company, launched a fourth brand (*Rigevidon*), in mid-1998, but it failed to establish itself on the commercial market. At 40 Pesos (PhP 40)[15] per cycle, it was the lowest-price SOMARC brand. It is important to note that most of the growth of the commercial market has been in the high-price pill category, although *Nordette*, one of the former SOMARC brands, is still a market leader.

In its 1998 evaluation of the SOMARC program, POPTECH made some observations that were highly predictive of the project's eventual impact:

> Manufacturers have tended to allocate SOMARC a brand, then leave it the task of enlarging its marketing share. Meanwhile the manufacturers, in particular Schering, have concentrated on promoting their other OCP brands. Only Wyeth with *Nordette* achieves any sort of income from present Couple's Choice sales through drugstores. It should not be surprising that these companies lack interest in [social marketing] or are unwilling to invest significantly in its future.[16]

Currently, SOMARC brands represent only 16 percent of the total market volume (versus 20 percent in 1994). This statistic is understandable, as higher margin products and one low-priced brand, *Trust,* were introduced in the years following the graduation of the SOMARC project. All four brands are still available, but Wyeth and Schering admit that they are not actively

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[14] Mallari, Edelweiss Balbin, Mark Sherman, and Dr. William Winfrey, *Commercial Contraceptive Marketing in the Philippines,* (The Policy Project, 1998)

[15] Approx. exchange rate as of February 2002: PhP 50 = US$1

[16] Adamchak, Susan E.; Emelina Soriano Almario; Laurie Emrich; Christopher Hermann; and Richard C.L. Pollard, *Midterm Assessment of Intermediate Result 3 of Strategic Objective 3: "Increased Private Sector Provision of Contraceptives and Family Planning / Maternal and Child Health Services"* (POPTECH, 1998)

promoting theirs. Organon is still promoting *Marvelon*, but its price has been substantially increased.

The SOMARC experience highlights two key aspects of the commercial contraceptive market. First, international companies tend to revert to a high-price, high-margin marketing strategy when funding for a social marketing project is terminated. This behavior may translate into price increases or result in reinvesting the margins made on low-priced products on more profitable products. Second, the most carefully designed partnership can be undermined by a fundamental change in the market, such as the introduction of a highly subsidized brand. Although the sales of *Trust pills* did not become significant until 1996, it is safe to assume that its presence on the market has affected the growth of former SOMARC brands.

Local Suppliers of Oral Contraceptives

Two local companies are marketing OCs: Pascual, a pharmaceutical manufacturer and distributor, and Marketlink, a marketing and importing agent for pharmaceutical products. These companies are marketing two brands of locally produced oral contraceptives: *Micropil* and *Perlas*. These brands are both low-dose monophasic pills retailing for PhP43 and PhP44 respectively. Pascual manufactures Perlas for Marketlink and its formulation is similar to that of *Micropil*, with the addition of iron.

Currently, *Perlas* is not distributed in retail stores, as Marketlink chose to first promote the brand to providers and midwives. Pascual and Marketlink are attempting to forge a close relationship with the DOH and midwives' associations as a way to build trust in their products. They describe their target group as belonging to middle and lower-middle income segments.

It is unclear why Pascual was not approached by SOMARC at the onset of the project, but the 1998 POPTECH report indicates that SOMARC had expressed interest in "taking over the locally produced *Micropil* brand from Pascual". The company did produce pills for DKT in the early 1990s, only to be replaced by Jenapharm, a subsidiary of Schering. Pascual appears to be interested in being a partner in future social marketing programs and is likely to benefit from increases in demand from low-income users, as its prices are the lowest after DKT's.

Non Profit Organizations

DKT is funded by the German Government through KFW and is a recipient of continued subsidies for the procurement of contraceptives. While DKT reinvests all its sales revenue in the project, none of it goes towards commodity procurement. DKT maintains very low prices on the grounds that it targets the poorest consumers in the Philippines - precisely those who stand to lose the most in the case of a donation phase-out by USAID.

As it is operating at the margins of the public sector and the lower end of the commercial sector, DKT receives both praise and criticism. On one hand, it is credited with recruiting large numbers of new users to the private sector, and on the other, it is often accused of "cannibalizing" the private sector by undercutting commercial prices. The only way for DKT to become sustainable in the long run is to adopt more of the tactics of the commercial sector: increased emphasis on higher-margin products, reduced investments, and product diversification. DKT is planning to launch new brands of condoms and pills at cost-recovery prices and is considering the introduction of an IUD and a new injectable in the near future.

The Family Planning Organization of the Philippines (FPOP) is a non-profit organization affiliated with the International Planned Parenthood Federation (IPPF). It provides family planning products and services at affordable prices in 35 clinics in 26 provinces. Though FPOP distributes small quantities of contraceptives, it is aware that a phase-out of USAID donations to the DOH might increase demand for its services. FPOP procures several brand-name contraceptives (such as *Marvelon, Nordette, Triquilar,* and *Excluton)* and distributes them through a network of midwives, who resell them at approximately half of the regular retail price. Although the products sold by FPOP are procured le gitimately from the manufacturers themselves, local affiliates and distributors essentially tolerate their presence on the market. This tolerance is unlikely to survive substantial increases in volume, which could jeopardize the manufacturers' commercial business in the Philippines. Consequently, FPOP has limited potential as a source of contraceptives unless it switches to brands not sold in the commercial sector.

Distributors and Retailers

Although distributors and retailers play a crucial role in making products available and visible in retail outlets, their ability to influence marketing decisions is limited. The three international suppliers of oral contraceptives distribute their products through two large distributing companies: Zuellig Pharma and Metro Drugs. These companies will endorse marketing decisions made by the pharmaceutical companies as long as promotional budgets and incentive plans reflect these strategies. The CMS team found no evidence of personal objections to distributing contraceptives on the part of distributors and their policies tend to be extremely pragmatic – sales forces are not encouraged to spend much time promoting low-margin or low-volume products, and contraceptives are no exception.

Retailers have the ability to limit the visibility of contraceptive products and have been known to do so. Because of their proximity to the public, retailers are likely to be politically vulnerable and concerned with the threat of consumer boycotts. Mercury Drug, the largest pharmaceutical retailer in the Philippines, pressured its affiliate, Philusa, to avoid high-profile condom promotional activities. The company's 400 drugstores, however, carry a full range of contraceptive brands at various prices and appear to have no plans to alter this policy.

Brands, Prices and Market Evolution

A variety of brands and formulations of oral contraceptives are found in the private sector. Prices range from PhP 25 to PhP 330 for a cycle. Table 6 lists consumer retail prices for OCs.

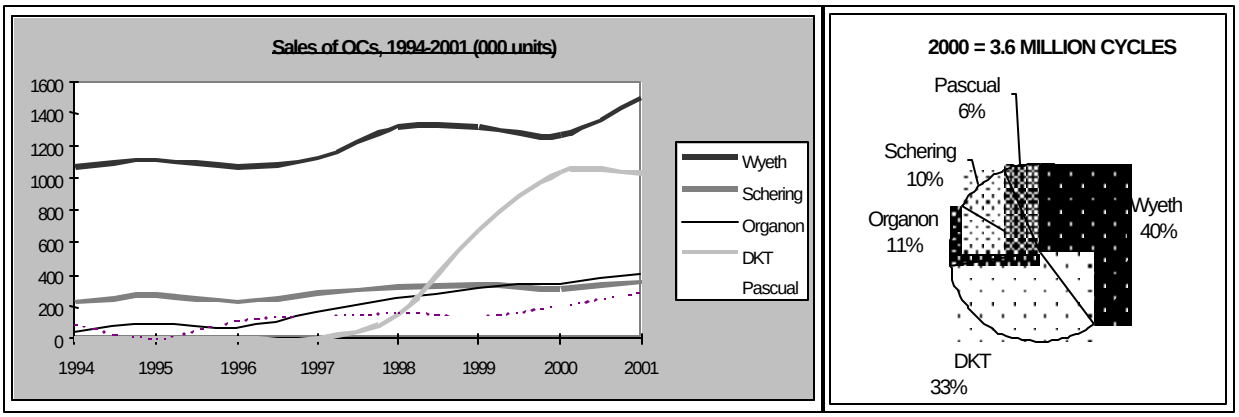
Table 6. Retail Prices for 5 best-selling OC brands (2000)

Brand	Retail price (PhP)	Sales (units)
Trust (DKT)	25.00	1038,000
Femenal (Wyeth)	103.00	415,000
Nordette (Wyeth)	89.45	342,000
Trinordiol (Wyeth)	148.80	297,000
Micropil (Pascual)	41.00	204,000

Prices for OCs vary widely, reflecting the existence of two distinct markets: middle and upper middle-class women who seek products and services at private sector facilities and lower-income women who essentially buy OCs over-the-counter from pharmacies. Filipino women also tend to stick to established brands that have been used by their friends and family, explaining why *Femenal* is still a top seller despite being a high-dose monophasic product with potentially higher side effects.

Sales of OCs in the private sector have experienced continuous growth since 1994 (see chart 4). DKT, which markets *Trust pills*, was responsible for the biggest volume increase between 1998 and 2001. As a result, the current competitive context is different today from what it was in 1997 and DKT now accounts for 33 percent of the market in volume.

Chart 4: Sales of OCs since 1994 and current market shares

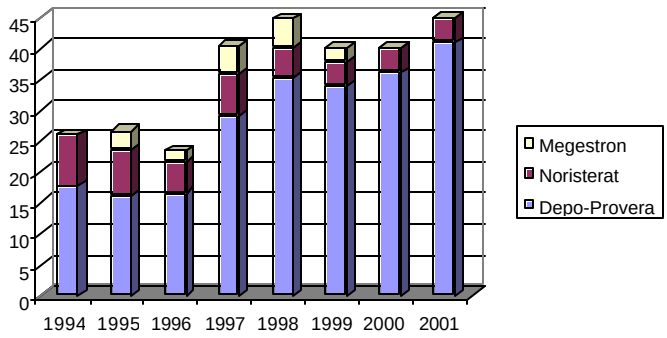


Source: IMS Health

Injectables

About 3 percent of married women use injectables in the Philippines. The vast majority of them (92 percent) obtain them from public health centers, particularly rural centers. The private sector market for injectables is extremely small, representing less than $100,000 in annual revenue. Combined units sold in 2000 amounted to approximately 10,000 couple's year protection (CYP) (see chart 5). In contrast, USAID donations to the DOH represented 670,000 CYP.

Chart 5. Sales of Injectables (thousand vials)



Currently, there are two brands of injectables on the commercial market: *Depo-Provera*, manufactured by Pharmacia, and *Noristerat*, made by Schering[17]. *Depo-Provera* which retails for about PhP 140 ($2.74), provides protection for three months, while *Noristerat* provides

[17] Organon discontinued its injectable *Megestron* in 2000.

protection for two months. With its PhP 262.25 price tag, *Noristerat* clearly is targeting upper-income women. *Depo-Provera* was introduced by SOMARC in March 1994 under the Couple's Choice program. The launch was supported by radio advertising and promotion, which generated substantial consumer awareness, but also attracted the ire of the Catholic Church. A church-led boycott against Pharmacia dampened the company's detailing and promotional activities.

Today, Pharmacia remains determined to develop *Depo-Provera* into a mainstream family planning method. Its Philippine affiliate employs a full-time product manager for the brand and is investing in training and detailing activities with midwives. A massive and sustained effort to convert providers, however, would be needed to gain acceptance for this new method around the country.

Pharmacia is considering a number of strategies to develop the injectable market, including the possibility of supplying discounted products to midwives and/or to DKT. Pharmacia appears to be looking for partnership opportunities that will ensure fast increases in volume sales while limiting the company's exposure to a public backlash.

Intra-Uterine Devices (IUD)

Less than 4 percent of married women use an IUD as a method of family planning. This method has been provided almost exclusively through the public sector. Donations of commodities to the DOH have averaged 140,000 pieces a year for the past 12 years, which is roughly the equivalent of 500,000 CYP. Schering and Organon removed their commercial IUDs from the market in 2000 because sales were too low. It is unlikely that these companies will reintroduce the product unless a substantial increase in demand materializes in the private sector. Although 16.6 percent of users had their IUD inserted by a private provider in 2001, the product could have been obtained from public sector facilities as is often the case in other countries where commercial IUDs are costly or hard to find.

Remarks about the Pricing of Pharmaceutical Contraceptives

In its 1998 study of contraceptive marketing in the Philippines, the POLICY Project attempted to explain why the prices of pharmaceutical contraceptives in that country are among the highest in Asia. Though the study did not establish with certainty the reason for these exorbitant prices, it did provide insight into the way pharmaceutical companies reach pricing decisions.

As evidenced in Table 7, the transfer price and gross profit margin are the largest components of consumer prices, while taxes and duties are comparatively small. It is important to note that the absence of price controls in the Philippines allows pharmaceutical companies to price their products according to desired levels of profitability and other marketing considerations, rather than as a result of a negotiation with regulatory boards. As highlighted in the POLICY Project's study, prices typically are influenced by the prices of other brands in a given market niche, as well as the price needed to generate minimum established profit margins.

In addition to these criteria, it should be noted that products within a given category could bear different profit margins. Furthermore, the margin generated on any given product might not be reinvested on that item, but used to finance the cost of marketing other goods deemed more strategic. Moderately priced contraceptives rarely are considered strategic, as it would take

much more growth in volume to generate the same profit levels from these products than from high-margin products. This reasoning explains in part why the world's leading contraceptive makers often show limited interest in developing new low-cost products, while being equally reluctant to reduce their margins on existing products since this margin can be used to develop more strategic products.

Table 7. Pricing of a Typical Pharmaceutical Product[18]

Component	Share
CIF or transfer price (fixed price from supplier)	30 to 40%
Bank and financial charges (depending on volume)	2 to 4% of CIF
Clearing charges	0.6 to 1% of CIF
Customs duty (if not exempted)	0 to 10% of CIF
Total landed cost	40 to 50%
Gross profit margin	40 to 60%
Price ex distributor (without VAT)	**90.91%**
	+
VAT	**9.09%**
TOTAL ex-distributor price	**100%**

Local manufacturers of contraceptives are not bound by transfer prices charged by their headquarters, but must assess the cost of dedicating production time and equipment to each product line. For example, *Pascual* tends to favor products that have high sales or profit potential as it allocates production resources to its different product lines.

Pricing by non-profit organizations follows a different strategy. As profit generation is not their primary purpose, prices are generally calculated according to average population income or what research says low-income people are willing to pay. This principle is bound to change, however, as organizations such as DKT seek to recover the cost of commodity procurement and increase their overall sustainability.

A particularly pressing question is whether the low-income segment is able to afford the products currently found in the private sector. One way to determine this would be to conduct studies on the willingness to pay among low-income people. Another method would be to utilize commonly used standards, such as percentage of income. For example, if one chooses 1 percent as the maximum percentage of income that people can invest in a family planning method, only those couples with an annual income higher than PhP 32,500 (about $630) could afford the cheapest brand on the market, DKT's *Trust*. If the two cheapest brands (*Trust* and *Micropil*) were removed from the market, only those couples earning more than PhP 115,700 (about $2,243) would be able to afford the next cheapest brand. This underscores the importance of social marketing brands for the low-income population.

[18] Adapted from Mallari, et al., *Commercial Contraceptive Marketing in the Philippines* (The Policy Project, 1998)

Condoms

Condom use in the Philippines is reportedly low for married couples. According to the 2001 Family Planning Survey, only 1.7 percent of married women opted for the method. In contrast, condom use is high among groups at risk of contracting sexually transmitted diseases or HIV (the HIV Sentinel Surveillance System reported 69 percent condom use among registered commercial sex workers in 2000). DKT and other NGOs are more likely to promote the use of condoms to prevent sexually transmitted infections and HIV than as a family planning method—in part because this is a less controversial approach in the Philippines.

As married women are less likely to use condoms than other groups, the fact that 43.5 percent of them obtain their condoms from the public sector[19] is of limited relevance in terms of contraceptive security. It is, however, important to know where the rest of the condom users obtain them. This information was not made available to the assessment team, but might be available through the various organizations working on HIV and STI prevention. Some of these organizations, notably DKT and Kabalikat, have expanded the availability of low-cost condoms by selling to motels, nightclubs, bars, and sometimes directly to high-risk groups.

USAID condom donations ranged from a high of 24 million in 1992 to a low of 3.5 million in 1997. The 2001 donation was 7.3 million, which represents about one fifth the number of condoms sold through the private sector in 2001 (about 35 million). This data is further evidence that condoms are primarily obtained in the private sector.

Brands, Prices, and Key Suppliers

There is a limited range of condom brands available in the private sector, but a good variety of prices can be found (see Table 8). The most affordable brand is *Trust*, which retails for PhP 5 (for a three-condom package) and as low as PhP 1 when sold through Kabalikat peer educators. The most expensive brand appears to be Benetton, at PhP 50 (X3). The two main distributors of condoms in the private sector are DKT and Philusa, a local commercial importer and distributor of consumer products.

Philusa was approached by SOMARC in 1992 to participate in a condom social marketing program. Its lowest-priced condom, *Sensation*, was the object of a mass media campaign that focused heavily on STI/HIV prevention. Condom sales increased by 78 percent in 1993 and 50 percent in 1994, reaching their highest level of 1.6 million. Sales decreased substantially in 1995, however, and the program was graduated from USAID funding the following year. Former SOMARC staff members felt that the conservative views of Philusa's owners were partly to blame for the program's mixed results.

Today, Philusa continues to distribute the same range of condoms as it did in 1994. The company does not seem to have any plans to increase its range of products and keeps promotional activities at a minimum. As it is the only supplier of condoms to the country's biggest drugstore chain (Mercury Drug, a sister company) Philusa maintains sales at a respectable level, although the company admits that growth is modest.

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[19] *Family Planning Survey* (National Statistics Office of the Philippines, 2001)

DKT accounts for most of the growth of the condom market since 1990. *Trust* represents about 66 percent of total condom sales, with 23 million units sold in 2001. The organization recently introduced *Frenzy*, another low-priced condom brand targeting urban youth in the B and C (low income) socio-economic category. Also, DKT is considering the introduction of a new upscale condom brand at a full-cost recovery price that is expected to contribute to the financial sustainability of the organization.

Table 8. Most Common Condom Brands

Brand	Retail price (PhP)
Trust*	5.00
Frenzy*	7.50
Sensation	21.75
Fulex	24-30
Lifestyles	30-35
Okamoto	20-50
Benetton	50.00

* subsidized social marketing brands

As procuring condoms is relatively easy and their marketing is uncomplicated, other organizations may be looking at the possibility of launching new brands in the future. For example, Friendly Care is considering marketing its own brands of condoms at prices that will generate profits and contribute to its financial sustainability. Whether the market can absorb new condom brands and grow in the process depends on the level of demand creation generated for the category.

C. Prevailing Strategies among Private Sector Contraceptive Suppliers

Target Groups

The contraceptive market clearly is segmented according to socio-economic criteria. International companies are actively pursuing the A-B (high income) socio-economic groups, while local manufacturers have chosen to cater to the large C (middle income) segment. DKT is positioned to attract the lowest income groups (C and D), although it is possible that its clientele overlaps with that of local suppliers. There is no evidence that any private sector supplier is targeting rural areas, with the possible exception of the FPOP. In fact, a market segmentation study by the POLICY Project stated that "among rural contraceptive users, all market groups disproportionately use the public sector."[20] This behavior is most likely a reflection of lack of access in areas where the private sector does not invest.

[20] Alano, et al., *Family Planning Use in the Philippines: Market Segmentation Study* (POLICY Project, 1998)

Perceptions of Public Sector Users by Private Sector Suppliers

When asked about the potential that current public sector users represent for the private sector, most suppliers (particularly international companies) expressed skepticism. There is an assumption among them that public sector users come primarily from low-income groups. For this reason, commercial suppliers expressed little interest in taking advantage of a possible donation phase-out by USAID. In reality, the market segmentation study revealed that a sizeable percentage of middle- and high-income users obtain products from the public sector. The market segmentation study report did not provide the data needed to quantify the number of public sector users who represent *true* potential for the private sector. This group would have to be composed of women who have middle to high income, live in urban areas, and are obtaining contraceptive supplies in the public sector. Such information would prove useful in persuading private sector suppliers that some public sector users could become their customers.

Support for Private Sector Initiatives

Commercial companies in the *Couple's Choice* program were hesitant to renew their involvement, mainly because the SOMARC approach involved lowering their prices so that low-income people could afford their products. There is a feeling among these companies that lowering the prices of select products may not be enough to capture the poorest, yet could cannibalize the sales of their high-price products. In fact, Schering and Wyeth consider the low-income segment to be a different market altogether, one that they cater to through their institutional sales to USAID and governments. Nonetheless, commercial and non-profit organizations expressed interest in being involved in discussions about contraceptive supply issues. In addition, they welcomed any intervention that might create demand for family planning.

D. Increasing the Private Sector's Contribution to Contraceptive Supply

Challenges

The public sector has been responsible for much of the demand creation efforts in the past decade, as well as for most of the supply. As consumers in various socio-economic classes realize the value of controlling the size of their family, however, they are more likely to demand a wider choice of methods and products and are more likely to pay for them. Private sector companies have responded to the increased demand for contraceptives by expanding their range of products and competing for customers. With expanded access to insurance coverage, even low-income couples may gain access to high-quality commercial products. The sustained availability of contraceptives to these couples, however, requires strategies that grow demand and supply in the private sector.

Another condition for a healthy private sector is fair competition. The private contraceptive market is growing, although much of this market is dependent on donor funding or other subsidies. Private sector organizations present various degrees of sustainability with commercial, for-profit companies being the most financially sustainable and NGOs being the least. A de-facto segmentation of the market appears to have occurred, with commercial companies catering to A/B/C consumers and non-profit NGOs catering to C/D consumers. As a result, requiring non-profit organizations to become more sustainable may encourage them to target segments that are sought by commercial companies. Similarly, encouraging commercial

companies to target low-income people may duplicate programs being channeled through social marketing organizations. The worst possible consequence of attempting to change the current dynamics would be that all contraceptive suppliers end up competing for the same pool of consumers, without investing in demand creation programs.

Opportunities

The fact that many Filipinos already use private sector facilities (particularly for services other than family planning) indicates that the private sector has significant advantages over the public sector, in spite of the cost. A study by the PROFIT project in 1996[21] indicated that private sector facilities ranked higher than public ones in the top four criteria for choosing a family planning service provider: cleanliness, effective medicine treatment, courteous staff, and privacy. On the other hand, private sector providers ranked low in terms of affordability, range of methods available, and accessible locations. Therefore, with the proper referral system to facilities that can provide a full range of methods, people might choose the private sector in much greater proportions. This switch would have important implications for long-term methods, such as IUDs and injectables.

In addition, a large portion of consumers are already obtaining short-term methods from private sector pharmacies. Demand has been growing steadily for pills and condoms, leading to increased interest from some local companies in marketing low-cost pills. DKT and Friendly Care are looking at product introductions in the coming months, which would offer consumers even greater choices. Finally, Pharmacia, the leading international supplier of injectables, is showing interest in investing in the method, despite its marginal use in the Philippines. This increased interest could be the opportunity to create demand in the private sector earlier, instead of developing new donation-dependent programs in the public sector.

E. Suggested Strategies

A good strategy to promote private sector initiatives in the Philippines should do no harm, avoid cannibalization between programs, and avoid working at cross-purposes with other donors. Among the possible interventions that are unlikely to produce favorable results are:

- Providing support to subsidized organizations that may compete with other organizations in the same market segment. This conflict would occur if organizations were encouraged to introduce social marketing products to the market. While this may solve a temporary supply gap, it would also have the effect of creating increased competition for the commercial sector and other NGOs. Instead of competing by investing more on their own brands, it is possible that some commercial companies might get out of the business of marketing low-cost contraceptives altogether.

- Partnering with private sector suppliers to put more products on the market in the absence of any increase in demand (such as launching another low-price OC that will compete with *Trust* or *Micropil*). Contraceptive suppliers are responding to a specific level of demand. If increases in demand materialize, then the commercial sector will likely adapt to this change

[21] *Consumer Survey on Preferred Source of Basic Health Care and Family Planning Services*, (PROFIT, Deloitte Touche Tohmatsu, 1996).

by increasing capacity or launching new products. Conversely, if demand does not increase for commercial products, launching new products will only create a glut. Therefore, attempting to address tomorrow's demand by tinkering with today's supply would have a negative impact.

- Attempting to convince commercial companies to reduce their margins substantially in exchange for subsidies. The SOMARC experience failed to demonstrate that a partnership based on these terms could develop sustainable demand for low-price contraceptives. The problem with this approach is that commercial suppliers, particularly international pharmaceutical companies, are unlikely to take any action that might threaten their high-earning products. In the absence of a foreseeable increase in demand from low-income population groups, no manufacturer will take the risk of switching current users to lower-priced products.

Strategies that are likely to have a positive impact on the sustained supply of contraceptives through the private sector include:

- Sharing plans and strategies with other donors to determine contraceptive supply needs for the next five to 10 years. Private sector suppliers need access to research and statistical information that can help them assess future increases in demand. Knowing how many people are likely to need contraceptives and what they are willing to pay will help the strategies of all players on the market.

- Identifying companies with an interest in serving the needs of middle- to low-income users and negotiating possible partnerships to create demand for and increase the supply of OCs, injectables, and IUDs. A phase-out of donations is most likely to benefit companies that cater to middle to low-income consumers (such as Pascual, Marketlink, and Philusa), which makes them natural partners for social marketing interventions. In addition, internationally-based companies can be included in demand creation activities that direct people to their lower-priced brands.

- Support social marketing programs that may be instrumental in ensuring adequate supplies of affordable products, but that need to be a part of a phase-out strategy rather than stand-alone initiatives. Pharmaceutical companies tend to regard the contraceptive business as compartmentalized: on one side the commercial market (A/B consumers) and on the other the institutional business (donors and governments). Until these companies become convinced that the institutional side of the business is diminishing, there will be few incentives for them to pursue low-income target groups.

- Addressing contraceptive security in coordination with other donors. The sustainability of programs cannot be construed in isolation of the rest of the market, for one player's gain in market share is often another's loss. As many of the public sector users may be below the poverty line, some degree of subsidy probably needs to be factored into a donation phase-out strategy. Funding will be best utilized in ensuring that supply and demand grow in the private sector and that a reduction of reliance on public donations does not come at the expense of contraceptive prevalence.

1. Strategies by Method

Oral Contraceptives

One of the best ways to affect the ratio of users going to the private versus the public sector is to focus on demand, not supply. Manufacturers interviewed by the CMS project reiterated a comment made to the POPTECH team in 1998: "the primary constraint to increased sales is the social attitude toward use of modern contraceptives and the availability of free public sources". Clearly, demand needs to increase and it needs to grow outside public sector facilities. One way to cultivate this demand is to design communication campaigns that promote modern methods and refer people to commercial brands sold in pharmacies. While SOMARC aimed to do this with its *Couple's Choice* campaign, it overlooked the fact that low-income people are more likely to buy their pills over the counter. Its emphasis on provider training and detailing would have been more appropriate for injectables, which depend heavily on provider intervention, than for pills.

For this reason, it is a good idea to encourage switching OCs to over-the-counter status. The real benefit of this change in the law would be to convert them into consumer goods that can be freely advertised. In the meantime, an umbrella campaign designed to promote pills in a generic fashion could still be beneficial, as long as it clearly indicates that the private sector offers the widest range of formulations and choices.

The best opportunity for the sustained provision of affordable contraceptives in the Philippines appears to be with local manufacturers/marketers that are already catering to middle- to low-income people. Two companies, Pascual and Marketlink, have demonstrated an interest in targeting middle to low-income customers and should be encouraged to prepare for increased demand in case of a phase-out of donations.

CMS recommends investigating the quality of *Micropil* and *Perlas* to ensure that users of *Lo-Gentrol* (a donated product to the DOH) will have access to products of comparable quality in the private sector. Should the quality of these products prove satisfactory, USAID should assess the ability of Pascual and Marketlink to sustain increased demand. It is unlikely, however, that these companies will increase their capacity preemptively. Pascual has admitted to occasional stockouts, caused by its strategy to limit overstocks of products that have a limited shelf life. As a result, close communication regarding foreseeable increases in demand will be necessary to ensure adequate supplies.

Injectable Contraceptives

Pharmacia has indicated a strong interest in developing demand for this class of products. These efforts should be coordinated with other activities aiming to increase access to family planning services in the private sector. For example, efforts to organize and train midwives can be linked with product training by Pharmacia. The section of this report covering service providers proposes activities that have important implications for the marketing of long-term methods.

Pricing does not to appear be a major issue when it comes to this method. *Depo-Provera* offers three months of protection for PhP 139.25, which is the equivalent of using a pill priced at PhP46. Clearly, some people cannot pay this much for contraception in the Philippines, but the private sector may not be the proper channel to cater to the poorest. At current prices, there is a lot of room for growth for *Depo-Provera* – not just in upper-income categories.

Therefore, we recommend that any effort to develop the provision of injectables through the private sector be done through a program that primarily will focus on demand creation. To ensure that new users are directed to the private sector rather than to public clinics, this program will need a strong provider component that can expand and reinforce current training and detailing efforts by Pharmacia.

IUDs

IUDs are no longer available in the private sector; USAID, therefore, should not discontinue donations until one is reintroduced. It is likely that as IUDs become difficult to find, commercial brands will reappear on the market. Partnering with an organization that can provide IUD insertions and resell to the private sector, possibly FPOP (the IPPF affiliate) or Marie Stopes, will accelerate this process. In time, DKT probably will respond to the USAID phase-out by introducing an IUD, which would solve the problem of availability, but not sustainability.

As in the case of injectables, IUD availability and affordability is intricately linked with that of provider services. Launching an IUD is less critical (and certainly less complicated) than ensuring that women have a place to go for affordable IUD insertions. For this reason, we refer the reader to section VI (Services and Providers) for ways to make long-term methods available in the private sector.

Condoms

As limited numbers of users are likely to be impacted by a phase-out of condom donations, USAID may want to begin scaling back its condom distribution program. While there does not appear to be a need for additional low-cost condom brands on the market, the same coordination exercise recommend for OCs should take place with condom suppliers. A campaign to direct public sector users to condom outlets, together with intensified communication about affordable condom brands, may be needed to aim users towards the private sector.

2. Coordination of a Phase-out Strategy

The biggest opportunity for the private sector resides in USAID's decision to phase-out donations. The private sector tends to respond to a vacuum or a tangible market opportunity. Few contraceptive suppliers consider current public sector users to be potential customers, because they do not feel they can compete with free products. Government stockouts, on the other hand, are seen as an opportunity to recruit new users, as getting products for free is no longer an option. This practice makes it difficult to prepare for a phase-out before it takes place. As contraceptive suppliers begin to realize that USAID's strategy is changing, however, they may be more willing to help shift public sector users to the private sector. CMS recommends developing a comprehensive phase-out strategy that would include the following steps:

- *Publicizing decisions regarding a possible donation phase-out* and renewing the dialogue with the private sector regarding contraceptive security. While commercial suppliers often are invited to conferences and workshops that address family planning issues, they are rarely kept abreast of government or donor decisions. For example, contraceptive suppliers have expressed disappointment at the lack of follow-up on a proposed partnership through CII.

They also claim to have little information on workshops and other activities that typically involve only the DOH, cooperating agencies, and USAID-funded NGOs.

- *Assessing the sustainability of current private sector suppliers, particularly DKT.* Regardless of whom USAID chooses to fund or partner with in the Philippines, DKT is likely to be the prime beneficiary of a USAID donation phase-out. Any procurement shortfall by DKT likely will translate in increased sales by the nearest competitors (local suppliers of OCs). On the other hand, new product introductions by DKT may reduce the sales of other contraceptive suppliers. While we do not advocate discouraging donors from funding DKT – the NGO plays a significant role in creating demand for contraceptives – it would not make sense to develop partnerships with commercial suppliers if DKT is likely to soak up the influx of demand for low-cost contraceptives.

- *Assess the likelihood of donor substitution in the provision of donations to the Philippines government.* A decision by UNFPA to resume donations might be enough to nullify the effect of a USAID pullout on the private sector. While this may be beneficial for low-income users, it will also have the effect of reducing incentives for the commercial sector to target this class of users. In fact, it is likely that contraceptive manufacturers will show more interest in pursuing procurement contracts with UNFPA (as they would with the DOH, if it was willing to procure its own products) than marketing low-cost products in the private sector.

- *Determine a cost-effective mix of incentives and subsidies that helps meet the needs of all users.* A secondary analysis of the 1998 market segmentation study would provide needed information regarding the number of people who can afford commercial prices (or at least social marketing prices). Also, it could identify the size of the user population that cannot afford those prices or does not have physical access to private sector outlets. In addition to this secondary analysis, a willingness-to-pay study is recommended to determine the number of people who might still need access to free products and services. USAID should aim for a strategy that helps the commercial sector meet the needs of people who can and are willing to pay commercial prices (high-, middle-, and some low-income people) while channeling subsidies to a mix of social marketing and public programs that cater to the population's poorest.

VI. SERVICES AND PROVIDERS

A. Services

Recent surveys show that only 26 percent of family planning clients obtain their contraception from the private sector. A majority of these clients go to private hospitals, physicians who maintain private practices within hospitals (15.4 percent), or to pharmacies (8.1 percent) for their family planning[22]. Disaggregating these figures to look at the distribution by contraceptive method (for the private medical sector only) provides some interesting details (see Table 9).

Table 9. Private Medical Sector Distribution by Method (percent)

METHOD	1998 DHS	2001 FPS
Pill	22.7	27.9
IUD	15.8	16.6
Injection	7.5	6.3
Condom	54.1	53.0
Female Sterilization	32.7	27.6
Male Sterilization	49.0	21.8
Other / Folk methods	38.1	
TOTAL	**26.3**	**26.1**

It is interesting to note the relatively high percentage of those opting for female sterilization: 33 percent in the 1998 survey and 28 percent in the 2001 findings. Further analysis of this comparatively higher private sector utilization might provide some interesting insights into how private sector contraceptive care can be expanded. Some portion of this provision is probably because sterilization is a reimbursed service by many public (PhilHealth) and private insurers. Also, some portion of it is attributable to many women's opting for sterilization immediately after their last desired child is born, as well as how they go about selecting the clinic or hospital in which they deliver (i.e. do more opt to deliver at private sites?). Further, this behavior may be in part a function of the providers involved, their employment status, and possibly biases. For this reason, CMS recommends further review of these numbers and the phenomena behind them.

Related to this analysis, helpful insights might be gained from delving into the types of providers and institutions involved with each contraceptive method's delivery. Past research done by the PROFIT Project and others makes it clear that different types of providers, public and private, sometimes have biases for or against particular contraceptive methods. Such research can help pinpoint knowledge and attitude issues that need to be targeted, which can provide the foundation for subsequent medical detailing and training programs.

[22] *1998 National Demographic Survey* (Macro International)

As in other countries, most private Filipino clinicians are located in urban areas, yet half of Filipinos reside in rural areas. Rural populations also tend to be less affluent and more reliant on public providers for medical care. Recent DHS data suggests that the differences in time to a FP provider for urban versus rural users is not significant. The median time to a provider for urban residents was 20 minutes, while it was 30 minutes for those residing in rural areas.[23] More research could be done to ascertain the availability of private providers in rural areas and the implications on programming approaches. This data suggests that commercial strategies will be of little relevance for poor rural populations. An exception might be specially directed social marketing efforts that could target harder to reach populations. As social marketing is often the most cost-effective way to make contraceptives available, even with such special conditions added to its design, it may warrant consideration.

The DOH's public clinic system is a fairly well developed network and is often the only option for primary through tertiary medical care in rural areas. For family planning care, this point is reinforced by the aforementioned 1998 DHS data that shows FP users in rural areas spend just a bit more time reaching their source of FP services and products than those in urban areas. In 1991, the national government transferred much of the budget and responsibility for health and family planning to LGUs. With devolution, nearly all funding for health and family planning service delivery is transferred in block grant-like appropriations to LGUs, which then fund and oversee services by public medical facilities at the barangay (village), municipal, and district levels. (As a result of devolution, local government was the fastest growing source of health expenditure, though it constitutes only 17.25 percent of the total. Second fastest were HMOs, constituting only 2.61 percent of total expenditures.)

Though this assessment team was unable to investigate private sector service quality, indications gathered from related statistics suggests that the quality of family planning services is at least somewhat of an issue in public and private sectors. High discontinuation rates are an important matter with all nonpermanent modern methods. Oral contraceptives, for example, have a 44 percent discontinuation rate in first 12 months of use and injectables have a 51.8 percent discontinuation rate.

Certification and/or accreditation of providers and institutions is of growing significance, due largely to the emerging influence of PhilHealth and also to the continuing efforts of the DOH and clinicians' professional associations. To the extent that commercial insurance companies are pursuing accreditation, they are reportedly concerned largely with financial standards rather than clinical competencies. In addition to these efforts, the DOH is supporting a seal of approval to differentiate public sector service providers by quality. All these forces bode well for improving the quality of care. Though a variety of groups are pursuing similar efforts, there appears to be a dialogue going on to streamline this process for the obvious benefits of efficiencies and effectiveness. Perhaps most significant are the efforts by the DOH and PhilHealth to dovetail their standards and practices. It could prove strategic and beneficial to weave the commercial insurance providers and managed care groups into this same process so public and private purchasers of health care are asking for the same standards. USAID should consider investigating, tracking, and perhaps investing in this area.

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[23] *1998 National Demographic Survey* (Macro International), p. 64

B. Providers

One of the challenges of working with private providers is that family planning almost always is provided within the larger context of primary and secondary care. In this context, providers respond to patients' expressed wants and needs. As delivery systems become better financed, and care norms begin to incorporate more standards for preventive service provision, this practice can change. Clinical trends like the growing awareness and difference to evidence-based medicine and the accrediting of providers can accelerate this change process. These trends have taken root in the Philippines; commercial and public insurance groups and clinicians associations are incorporating their contributions and facilitating their dissemination. These efforts might further be supported strategically by carefully invested donor support, though their contributions likely would appear only in the long term and would have a broad impact on healthcare, rather than just FP/RH/MCH.

One key detail in the DHS warrants comment: When reporting on the source of contraceptives, the largest category among private sector options is labeled "Private hospital/clinic." There is a second category for "Private Doctor, " suggesting a clear distinction between hospitals/clinics and doctors. Many private doctors, however, maintain clinics in hospitals or large clinics in which they see patients. Though the "Private hospital/clinic" category is responsible for more clinic-based services (like sterilizations), it is probable that this category also is capturing users who are seeing private doctors located in hospitals or clinics.

C. Professional associations

Obstetricians and Gynecologists

The Philippine Obstetrical and Gynecological Society (POGS) reports 2,000 certified Ob-Gyn members. POGS has worked with a few USAID-funded health/FP initiatives. It has an organizational structure that includes a board, an elected executive director that serves for a one-year duration, and 12 regional representatives who are practicing Ob-Gyns and volunteer their time for initiatives. When queried about their organization's position on family planning, the executive director noted that the stance is a function of the current executive director's personal position. Hence, there is not an organizational position for or against it. This director noted that he is personally supportive of family planning as a concept and readily supports it, but he could not assure us that any future director would feel the same.

Ob-Gyns' influence is disproportionate to their numbers because of the stature of the profession, the significant role and contact they have with women regarding reproduction, and the role they play with more service-dependent contraceptive methods (especially voluntary sterilization). For these reasons, POGS may be an appropriate group with whom to discuss partnerships. Given its limited organizational infrastructure, its possible commitments with other entities, and its potentially fluctuating commitment to family planning, such a partnership should be researched carefully.

Midwives

Though the Integrated Midwives Association of the Philippines (IMAP) reports 143,000 dues-paying members, a much smaller portion of these are engaged in active work as midwives. IMAP reports that of the total, 17,700 are employed as midwives in DOH public sector positions

(another 9,000 work for the government as sanitary inspectors or hospital attendants), and 10,000 serve in private sector positions. Of those working in the private sector, an unknown number maintain their own midwifery practices. Many work in private hospitals, clinics, and doctors offices as medical aides.

Midwives appear to be an obvious group of care providers with which to collaborate on MCH and family planning (and a number of USAID-funded projects have done so). They are able to dispense condoms and OCs; with special training they also can provide injectable contraception and insert IUDs. When considering them for private sector oriented initiatives, however, there are special challenges. Many midwives do not have an entrepreneurial or business oriented approach to their profession. Rather, many have opted for midwifery in the hopes of securing a steady government position and/or out of a sense of community service. Those who have worked with Filipino midwives report it can be challenging to identify those interested in taking the risks and putting in the extra hours needed to succeed as a private practitioner. An additional challenge with private sector initiatives is that because so many midwives work in the public sector and serve lower-income clientele, it is difficult for them to provide services on a fully-costed basis. They are perceived to be providers of free health services; when working outside of those clinics, they will be compensated only partially for their services and often paid in kind rather than in cash.

The JSI TANGO II project appears to have demonstrated that midwives can run successful commercial clinics. Unfortunately, the total number of midwives it was able to establish partnerships with has been limited and it might be costly to replicate on a regional or national scale. Additional assessments of this project would help document its impact and lessons. We also know from our discussions with pharmaceutical companies that some of them perceive midwives as valuable partners in the provision of commercial pharmaceuticals and products. A challenge that remains though is to find cost-effective approaches for reaching significant numbers of these midwives. Private projects in other countries (e.g. in India, CMS works with chemists and traditional doctors) have undertaken training and medical detailing approaches that may be relevant. A key step would be to identify and approach midwives who are operating commercial practices.

Family Physicians

Family physicians are considered a medical specialty group in the Philippines. This group receives its certification from the Philippine Academy of Family Physicians (PAFP), which notes having 7,000 certified members throughout the country. It is difficult to estimate the number of uncertified doctors who practice medicine. We were told that no development group has formed a partnership with the PAFP. It appears a particularly well-positioned group with which to partner due to the size of its membership, the role their members can play with provision of most contraceptive methods, the appearance of a more substantial organizational infrastructure, and the support of its executive director who serves for more than just a year.

D. Private Provider Networks

As noted above, private providers are primarily found in urban areas where there is sufficient population density for more profitable clinic practices. Providers, health care institutions, and investors all appear to be experimenting with a variety of private business constructs for networking health care delivery. In Manila, one can see a variety of such private sector provider

networks. Part of this development is fueled by the expanding purchasing power for health care that comes from an expanding middle class, and from increased health insurance options.

Well Family Midwife Clinics Network (TANGO II Project)

Given this assessment was concerned with a much broader and more general assessment of USAID's interface with the commercial sector, the tone of our conversations with TANGO II's Well Family Midwife Clinics Network and other private provider ventures is more anecdotal in nature. (Other groups have conducted more focused and thorough reviews of the TANGO II network and can offer more detailed findings.) Participating midwives now number 178, with an additional 60 midwife clinics supposedly due to open soon. The total number had been as high as 240 midwives, but with a significant drop out rate and attrition from quality standard applications, it is a challenge to maintain these numbers.

JSI and the participating local NGOs in this project have made some commendable strides in establishing and fine-tuning an approach to selecting, training (in clinical and business skills), and maintaining linkages with midwives that result in more viable private medical practices. Perhaps one of the more significant (and possibly obvious) points to make about this network is that the midwives are truly commercial providers operating in a competitive market place. With the exception of occasional concessionary arrangements for contraceptive supplies, the midwives operate in a commercial environment following their training.

Part of the challenge with assessing a project like this lies in how narrow or broad to focus the inquiry. Is it only a family planning project? Or should we consider its potential health benefits as well? Are we concerned more so with its commercial nature and impact or with the health side? What about its possible contribution for income generation and women's empowerment? All of these considerations (and more) may be important. Those funding the project, however, need to consider what they will use to measure its performance.

Several key questions should be pursued through an independent assessment of the project's outcomes and impact. Key aspects of this effort that that have not yet been tallied include:

- Of the current network midwives, how many were practicing before (in the public or private sector) and are they seeing greater numbers of patients now? If so, how many and for what types of services?
- Did these midwives patients' previously rely on public or private clinics?
- Before, where did patients source their contraceptives? Where are they getting them *now* that these midwives are seeing them?
- What other development, general health, MCH, and RH needs are being facilitated by this approach that may not be measured by a narrow FP-only assessment?

At present, the project staff does not have the funding or mandate to undertake such work in the remaining project life. Supporting such an assessment would be a sound investment, given how much has been spent by USAID for this valuable experience.

In addition to the training and development of these midwives, this project has had some unexpected but beneficial consequences on healthcare delivery. For example, PhilHealth has adopted TANGO's standards for outpatient birthing stations, for its own accreditation of such service sites. It has also created a couple of the practices that were selected by IMAP as winners of its annual outstanding midwife awards. These programs serve as important role models for other midwives.

One of the key questions that this project begs is whether the numbers of midwives ever could be expanded to a scale at which they could begin to have regional or national impact. Working with the current 200 midwives (when there are around 17,000 midwives in the public sector and possibly up to 10,000 working in the private sector) means this project's merit would seem to be limited to that of an important pilot project. According to those involved with the project, however, the total number of involved midwives will be approaching 300 by the end of 2002. If this number could be expanded to around 1,000 midwives, the project could move into a new and more strategic role beyond that of a pilot. Those involved in the project's implementation suggested it would be conceivable to think of a tripling of enrolled members to nearly 1,000 networked midwives.

The estimated number of midwives with viable private practices is significantly less than 10,000. Were this network able to expand its numbers to 1,000, the ratio of trained and monitored midwives to those without would be better than one out of ten. At this level, the training, quality, and customer service standards that have been reportedly successfully institutionalized by this network would begin to have a significant impact on the entire profession. This influence likely would translate into expanding accreditation and utilization by insurance providers, positive impact on midwife certification practices for ALL midwives, and the adapting of the more qualitative clinical norms that midwives perceive they should be emulating. For these reasons, as well as their strategic position in the MCH/FP care delivery system (in urban and the difficult-to-serve rural areas), USAID may want to reconsider its intended cessation of support to this midwife initiative.

A key dimension of this initiative's future growth and contribution is whether it can assimilate more cost-effective and efficacious ways to train midwives and expand and manage the network. The current network has had to inherit and continue using some structural vestiges from the past, in particular utilization of a large number of varied health/FP NGOs. Previously, USAID was concerned with contributing to NGO sustainability and that objective was tied up in this larger midwife network initiative. If USAID and the political climate were to allow the project management to select its implementing partners solely for their contribution to this project, it could open the project's capacity to expand considerably. JSI notes it attempted to take more of a franchising approach with the implementing NGOs early on, but this did not succeed.

Friendly Care Foundation

As mentioned in the Scope of Work, USAID Mission requested CMS to consider the Friendly Care Foundation in the context of USAID's larger efforts to nurture a greater role for commercial service delivery initiatives. USAID has strongly supported Friendly Care and considers this organization as a potential model for expanding private sector family planning services. To this end, the assessment team encourages USAID to track Friendly Care's performance and contribution to increased private sector service capacity, in order to determine its net contribution to overall private sector program goals.

Approaches USAID might use to track performance include:

- use of mystery shoppers to visit other private providers to determine the extent to which FP services are available;
- exit interviews with Friendly Care clientele to determine their past FP use and sourcing practices;
- an updated review of Friendly Care's service statistics and revenue/expenditures; and
- a review of its updated business plan.

Friendly Care has recently trimmed its headquarters management structure, and staff at one clinic location, which suggests it is getting serious about achieving leaner operations. This combined with the findings to the approaches noted above will help USAID determine whether its' assumptions were valid and whether objectives for this project can be achieved in the projected time frame.

E. Worksite Based Initiatives

Family planning professionals have appreciated the value of providing family planning services at worksites and have pursued this strategy for decades. It makes a great deal of sense in settings where workers do not have other convenient or affordable providers for health and family planning services. In the Philippines, these initiatives date back to the early- and mid-1980s and build on the Philippine government's mandate that all employers with 200 or more employees must establish a clinic at their work site that provides key health and family planning services.

Reports are that companies' compliance with this law varies widely. In some cases, the firms have no clinical personnel or special facilities; in others their clinic may be a nurse's aide hired to dispense first aid and aspirin from a small medicine cabinet. Companies can dispense contraception only if they have a registered nurse employed at the site.

NGOs who have worked with these companies report that they are able to achieve higher levels of contraceptive prevalence rate through such efforts. Undoubtedly there are companies that have gone to lengths to invest in the welfare of their workforce, including providing contraception upon request. These NGOs report they have had more success working with larger and international companies and promoting a combination of MCH care along with family planning, rather than the latter service alone. Some report they have achieved modern contraceptive prevalence rates of 56 percent among employees in their project areas[24] (national modern CPR is 32 percent). Typically, we were told that where worksites provide family planning, the commodities usually come from supplies donated by the DOH.

Interestingly, labor organizations are working on nearly identical initiatives. The Trade Union Congress of the Philippines (TUCP – a federation of 28 national labor organizations with 1.25 million employees) began family planning efforts in 1981, with funding assistance from the International Labor Organization. It pursued a similar strategy of creating health/FP service clinics at large employer sites, as well as providing education and information dissemination to

[24] From notes of interview with Marissa Reyes (PCPD)

employees. It now has 14 clinics across the country where there are the highest concentrations of workers. It claims these clinics and the outreach through the worksites reaches 33,000 workers with family planning services and another 60,000 with other reproductive health information. In addition to these service efforts, this labor organization advocates for health benefits inclusion in collective bargaining. (It also has initiatives to address HIV prevention and improve employees work conditions at sweatshops.)

As noted earlier, these efforts to establish worksite service provisions make sense when workers have no other option for obtaining services (as in remote areas, such as agricultural or mining operations). Many of the current worksites, however, are in urban areas where private provider options are probably available. More importantly, these employers are identified as the formal sector employees that should be participating in insurance plans. Given insurance coverage is expanding, and in time will cover outpatient services like family planning, it probably would make sense to modify program objectives to stipulate that FP services are covered (if not provided) and that employers promote the dissemination of health and family planning information and referrals rather than stipulate they provide the services.

F. Conclusions

When working to transform the commercial sector to achieve socially beneficial outcomes, it is usually more effective to change the factors that influence the environment in which business is conducted, rather than attempt to start new businesses that may compete with existing ones. In the current Filipino commercial healthcare environment, there are a number of points at which strategic influence can be leveraged to expand reproductive health and family planning services. Some of the more important leverage points include:

a. *Patient/client demand for services.* Though it sounds obvious, patients or clients increasingly requesting family planning services from private providers will translate near-directly into service provision. Thus, demand generation plays a direct and strong role in service provision, including if or how that demand may be steered towards a particular sector (like the private one).

b. *Reimbursement from insurance companies to providers for MCH/RH/FP*. Adequate reimbursement rates for these services coupled with demand for those services from patients will address a significant amount of what the private sector can contribute to expanding service coverage. This presumes that concomitant efforts are made to steer the more affluent users of public facilities towards private sources of care. That said, we realize that these two dimensions are also the most comprehensive and challenging to address.

c. *Updating of clinicians' care delivery and prescribing practices and reducing provider barriers through medical detailing and focused professional development training*. These improvements are most efficiently done through medical detailing and have been used successfully by commercial companies and development groups that hold true to a lean and minimalist approach to maintain such efficiencies.

d. *Employing additional means to influence providers and institutions' care practices.* These include influencing the accreditation standards for these providers and institutions. Another example is influencing and contributing to what providers are obliged to learn or relearn to obtain and maintain their board certification from their professional association, often

through regularly obtaining continuing medical education credits (CMEs) throughout their clinical practice.

G. Suggested Strategies

Given these conclusions and the prevailing environment in the Philippines, our recommendations for services and providers are:

1. Undertake demand generation activities that promote modern methods, address the reported concerns about side effects, and highlight private providers.

2. Work with private and public insurance groups to expand reimbursement for FP/RH services from insurance providers. This point is discussed elsewhere from the perspective of health financing, but is reiterated here due to the powerful influence it has on providers' attunement to and provision of services. There is promising movement already occurring on this activity. USAID should investigate whether there is more that could be done to accelerate this movement. This undertaking will undoubtedly be ongoing and longer-term, but it will make a valuable contribution.

3. Facilitate medical detailing and targeted training to pharmacists and key medical providers (such as Ob-Gyns, Family Physicians, and Midwives), possibly in consort with providers' professional associations and pharmaceutical manufacturers. This assistance also could be performed through a field staff of detailers that pay brief monthly visits (five minutes) to providers and pharmacists to convey key messages. Concise training modules that fit with these associations' practices and contribute to providers' CMEs and certification requirements also can be linked to this effort, prior to or during the detailing. We would work with select professional clinicians' associations through mechanisms they already use and appreciate - including member certification, CMEs, accreditation, and professional development training. These efforts need to be sustained for several years. When coupled with demand generation activities, these programs have been successful at raising method prevalence rates. These are also perhaps the most effective to identify and address provider biases with family planning and misunderstandings about particular methods of contraception. The high levels of method discontinuation reported in the DHS suggests providers are not doing as good a job as possible when prescribing contraceptives and managing follow up activities. Medical detailing and well-focused training modules are probably the most efficient ways to address these biases and knowledge concerns.

   As noted above, the professional associations we recommend prioritizing (given their membership, geographic reach, and organizational capabilities) are the PAFP, the Philippine Obstetrical and Gynecological Society (POGS), and the two associations representing midwives. The PAFP, with its 7,000 physician members and established leadership (that has expressed interest in collaborating), could be an influential force to impact perhaps the most widespread and numerous cadre of professional physicians.

4. The assessment team encourages USAID to track the performance of its current efforts to expand FP services, like those of Friendly Care Clinics, in order to determine these efforts' comparative contribution to private sector family planning objectives. Creating new medical service delivery infrastructure from the ground up is expensive and time consuming. Stipulating further that it emphasize low margin services like MCH and family planning

services further limits the potential revenues of the service model. Further, in urban areas of the Philippines where private providers are found, it is possible that efforts to create new clinics may end up creating services that are already available from existing private providers. It is therefore necessary to track not only what any development-supported projects are doing, but also what FP services the purely private providers in the same area may be providing, and what effects the project is having overall.

5. With the midwife clinics network project, at a minimum we encourage USAID to fund and support sufficient assessment and documentation of this project's outcomes and impact. According to the project's director, this project does not have the funds or scope to undertake such work. Ideally, an independent group (well versed in development-oriented health efforts, private sector strategies, as well as research methodology) should perform such an assessment. The findings of such work would be valuable to people in the Philippines and worldwide who are pursuing similar efforts to link, train, and improve the services of private providers. Additionally, we encourage USAID to provide sufficient time for the project to transition from USAID support, to a private consortium model it is developing.

6. USAID should reconsider its decision to cease funding of the midwife clinic network project. As noted, this project has produced valuable lessons and model for launching and supporting midwives in commercially successful service delivery clinics. Were it to be expanded threefold, (to roughly 1,000 midwifes – which would then constitute more than one of every 10 private midwives nationally - an feasible increase), it could start to have a strategic influence on care practices and overall private sector service supply.

7. With the DOH, MSH, and select LGUs, USAID should devote additional resources to pilot test approaches for identifying and reimbursing the care needs of targeted low-income populations.

8. Refocus or revise employer-based program objectives from the current objective of attempting to create actual clinics at worksites to one of using relationships with employers and labor organizations to:

   - increase enrollment in insurance plans among employees; and
   - undertake work-site promotion of key services and their utilization.

   As formal sector employers are being asked to provide health insurance for their employees, attempting to establish worksite clinics for these same employees would result in duplicate services and expenses. The current approach makes sense if a worksite is geographically removed or isolated from any medical care providers. In other areas, however, where providers already are available, this is not an effective use of resources. Employers' compliance with this legislative mandate has been mixed. Offering a more cost-effective approach would probably appeal to a greater number of employers. Labor organizations should be approached to discuss potential collaboration around health and family planning initiatives along these same lines.

9. Influence practice norms through new medical care influences (e.g., evidence-based medicine, clustering of preventive services, etc.). For example, it could prove strategic and beneficial in the long run to weave the commercial insurance providers and managed care

groups into this same dialogue that PhilHealth and the DOH are having on accreditation of providers and health care institutions, so that public and private purchasers of health care are asking for the same kinds of standards.

10. Analyze information on contraceptive utilization patterns, looking method-by-method and by each type of key provider to identify factors that may be encouraging or discouraging clients' utilization of modern contraceptive services.

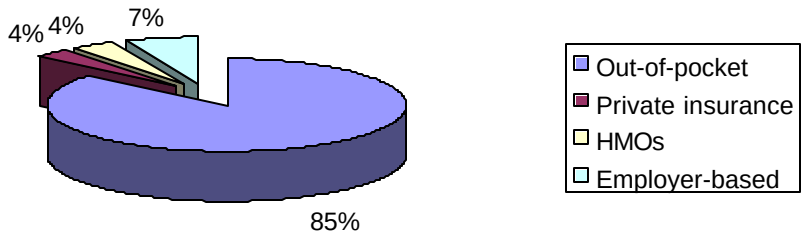
VII. HEALTH FINANCE

Total health expenditures in the Philippines have constituted an increasing portion of its gross national product (GNP), increasing from 2.98 percent in 1991, to 3.6 percent in 1998.[25] Though the World Health Organization (WHO) recommends that countries spend 5 percent of their GNP on health, the Philippines falls in the middle compared to its neighbors regarding health spending.

Of total expenditures on health, private expenditures constitute the largest category - 55 percent of total expenditures in 1998. Government expenditures made up 35.65 percent, and social insurance was 9.54 percent of total expenditures.

Breaking down the private expenditures, out-of-pocket" expenditures constituted approximately 85 percent of private health expenditures, private insurance was 3.5 percent, HMOs were 4.7 percent, and employer-based plans were 6.8 percent (see chart 6). Such high rates of out of pocket spending, along with high rates of poverty and low levels of insurance coverage, suggests a substantial portion of this spending went towards urgent needs like pharmaceuticals, hospitals, and doctors fees rather than health promotion/disease prevention services.

Chart 6. Breakdown of Private Health Expenditures (1998)



In the public sector, beginning in 1991, the national government transferred much of the budget and responsibility for health, family planning, other social services, and a number of civic functions (e.g. roads) to local government units (LGUs). With this approach, referred to as devolution, nearly all funds that were programmed previously and managed by the national government are transferred in block grant-like appropriations to LGUs. In the case of health and family planning, LGUs take responsibility for funding and overseeing these services that are

[25] *Philippine National Health Accounts* (National Statistical Coordination Board, 1998)

provided by the same public medical facilities at the barangay (village), municipal, and district levels that previously had received their funding directly from the national government.

As a result of devolution, local governments were the fastest growing source of health expenditure, (though they constitutes only 17.25 percent of total health expenditures) - faster than private health insurance, managed care, and social insurance.

Health insurance (through PhilHealth) is considered compulsory for those working in the formal employment sector (private and government). Approximately 45 percent of workers in these sectors are enrolled in insurance agreements (5 million from the private sector and 1.0-1.5 million in government). Expanding this insurance coverage is an explicit goal for government (to 85 percent of workers by 2004) – a goal that is not likely to be achieved, reportedly because of the government's lagging in its assigned payments.

Health insurance is almost exclusively for in-patient coverage only. A few private insurance plans are experimenting with expanded benefits for outpatient services and pharmacy benefits. MSH is doing actuarial projections for a range of preventive services with an eye towards helping establish some of these as covered benefits. Operational issues such as expanding provider networks and improving reimbursement practices are inhibiting insurance's more-rapid expansion. This problem is true for PhilHealth as well, but it is not surprising as such issues are a reality even in mature insurance markets and should not be considered an exceptional challenge. The private insurance companies with which we spoke were aware of these challenges and claimed they were addressing them. Insurance providers appear to be grappling with considerable levels of provider fraud and feel obliged to take different approaches to reimbursement to manage the financial risk.

A. Family Planning

The latest 1998 DHS reports that most users pay nothing or very little for their methods of family planning. (Unfortunately, this data does not disaggregate private and public sector users.) With OC users for example, about 80 percent of them obtain their monthly packet of OCs for less than PhP 24. Thirty-five percent of OC users obtained them for free. This price margin is close to what the current subsidized socially marketed OC sells for and is considerably below the next higher priced OC on the market.

With IUDs, 27 percent of users obtain their method for free. Thirty-two percent pay between 50 and 246 Pesos. With injectables (nearly all DMPA), a third of users obtain their method for free. Another third pay from PhP 1-19 and most of the remaining third (31.2 percent) pay less than PhP100. Similar information for voluntary sterilization was not available. This information highlights the considerable role that free and subsidized contraceptives currently play for users.

Insurance companies, private and public, acknowledged that there is little to no coverage of family planning services. Sterilization is the only consistently noted exception, when it is provided on an inpatient basis. DHS reports that a third of female sterilizations are performed at private medical clinics (distinct from NGO clinics). Insurance representatives noted that the clinic visit portion of a contraceptive visit might be covered, but not the actual commodities. In some of the social insurance experiments taking place, FP is typically covered. Further discussions are needed to gather more details on this aspect of coverage.

B. Social Insurance and Indigent Coverage

We were told different levels when asking about the number currently enrolled in indigent insurance plans – from 1.0 to 2.5 million indigents. PhilHealth reports its target this year is to enroll an additional 1.2 million people. Reportedly, the government hopes that PhilHealth will enroll 100 percent of indigents in the national health insurance system by 2010. A PhilHealth representative suggests indigents may constitute 35 to 40 percent of the 77 million population. This initiative would mean expanding coverage to 27 to 31 million people. PhilHealth reports it intends to use capitated rates as the basis for this coverage.

Along with this work by PhilHealth, there are a variety of social insurance experiments from which to learn. A recent study done by the Social Health Insurance Project (SHINE), financed by GTZ, reviewed 35 different community based health care organizations, many of which are in rural areas. PhilamCare, the largest commercial insurance provider, has an insurance plan that covers the sugar cane workers of Negros (an island in the Visayan region) through an agreement formed with the sugar cane workers association of Negros, as well as the owner/employers of the sugar plantations. The SHINE Project itself, housed and operating within PhilHealth, is working on local health insurance initiatives in two different local governments.

C. Conclusions

As we all know, efforts pursued in one sector can have a profound impact on other sectors. This fact is clearly the case in the Philippines where the availability of free and subsidized family planning products and services from public clinics has steered utilization towards those sources. More carefully targeting these free commodities and services would steer many users towards private sources. A certain portion, though currently unquantified, would not have geographic or financial access to those commercial sources. Expanding health insurance's reimbursement for FP to public and private providers at the same time that free commodities are more carefully targeted, would perhaps be the most influential strategy in the financing and insurance realm that would positively impact utilization.

D. Suggested Strategies

1. **Investigate assisting PhilHealth and other insurance companies to expand their benefits coverage of FP/MCH/RH services.** PhilHealth is already moving in an impressive fashion pursuing expansion of a number of valuable health services for its formal sector enrolled members as well as its social health insurance beneficiaries. It is extending coverage for outpatient sterilizations and IUD insertions beyond its current more limited coverage of only inpatient sterilizations. It is also developing an MCH benefits package that would cluster a number of key health and family planning services. This packaging, or clustering, of primary health care and family pla nning services makes sense for a number of reasons including the political sensitivity that promotion of family planning alone might create; we encourage USAID to support it.

2. **Provide PhilHealth with select technical assistance.** PhilHealth expressed interest in some specific and sophisticated technical assistance to address operational and growth challenges. These needs include assistance to develop PPO/IPA-type provider networks

with which they could affiliate, develop a pharmaceutical benefits management (PBM) program, and advice on how to control and manage costs they are billed for from ambulatory diagnostic clinics. These are issues with which U.S. managed care organizations grapple. Perhaps the best prepared to offer such technical assistance might be one of the more successful and philanthropically oriented nonprofit managed care groups in the United States that would be willing to consult and advise on these topics.

3. **Support PhilHealth's expansion of informal sector and indigent populations.** PhilHealth is attempting to rapidly expand its social health insurance coverage to 1 million informal sector and 1.2 million indigent families, with coverage for a total of 8 million families (approximately 40 million people). The expansion to informal sector and indigents potentially creates new markets for private providers – if these new clients avail themselves of PhilHealth benefits, go to private providers, and seek services in the private sector.

4. **Identifying alternative financing for services not covered by PhilHealth.** Though PhilHealth's goal is to provide 100 percent of indigents with insured health coverage within 8 years, it is likely to have difficulties achieving that target. Until it does, it may be helpful to explore alternative ways to finance the MCH and family planning needs of indigents through alternative means that might allow them to avail of care from public or private providers. The variety of social insurance experiments being pursued could be reviewed to add more background experience to this program effort.

   With family planning services and products, PhilHealth intends to expand coverage that will, in time, cover all of the more service-based methods. The only methods that probably will not be covered are OCs and condoms. As condoms are already affordable and frequently purchased in the commercial sector, the impact of not covering them might be small. For OCs though, the public sector is currently the provider for 76 percent of users. As long as affordable options exist, the need for free OCs may be limited to indigent women. PhilHealth, with additional support from the German development group GTZ, is actively expanding enrollment of indigents in its social health insurance mechanisms, while also researching how it can expand the services covered in those same mechanisms. We encourage USAID to support these efforts where possible. Further study will be needed, but perhaps a supplemental package might include OCs, essential drugs, vitamin A and iron folate tablets supplementation, and immunizations.

5. **Help ensure PhilHealth's expansion facilitates demand and utilization in the private sector as well as the public sector**. The ongoing changes at PhilHealth - expanding benefits and providing coverage to informal sector workers and indigents - present a critical opportunity to increase provision of family planning and other services in the private sector. CMS encourages further support to these new programs, with special attention to the impact on private sector service provision. Changes to supply and demand in the private sector should be monitored. For example, regarding supply, it will be informative to track the number and type of private service providers who are being accredited by PhilHealth. Are a range (e.g., Ob-Gyns, family physicians, and midwives) of providers seeking and receiving accreditation? For demand, are beneficiaries obtaining services from private sector providers? Where did these beneficiaries previously seek services? Monitoring can help ensure that these reforms are having the desired impact on private service providers.

VIII. POLICY

A. Influential Actors

For family planning, there are a number of key actors who influence the policy environment. These include the church, the government, donors, NGOs, commercial sector contraceptive manufacturers and private providers, and the business community. Each of these will be discussed.

The Church

The hierarchy of the Catholic Church, headed by Cardinal Sin, is strongly and vocally opposed to all modern methods of family planning. Cardinal Sin and the church represent a significant political force in the Philippines; many leaders in the public and private sectors are reluctant to incur its criticism. Further, the church has demonstrated its ability to mobilize opposition. For instance, when Pharmacia, through the SOMARC project, and the DOH introduced Depo-Provera, the Catholic Church organized a boycott of all Pharmacia products. Promotional efforts were curtailed. The international contraceptive manufacturers are still conscious of this precedent and continue to be cautious about promotional activities. Nevertheless, it appears as though the religious objections to modern methods are not unanimous. We heard mention of bishops and parish priests who understand the substantial need for modern methods of contraception and support their use.

The effects of religious conservatism appear to be more on the supply side than on demand. In a recent survey, less than 1 percent of women cited religious objections as their reason for non-use of family planning. Demand creation, however, suffers from the conservative environment. The Pharmacia experience creates caution regarding mass media campaigns to create demand. For the contraceptive manufacturers, this barrier is not the only one, as brand advertising of ethical products is prohibited. For individual providers, questions about family planning are not necessarily part of a standard health interview and many providers will only offer family planning when asked, for fear of offending Catholic clients.

Government

Under the current administration of President Gloria Macapagal-Arroyo, the government is not openly supportive of family planning. Secretary Dayrit of the DOH has indicated that the DOH will not procure contraceptives. This policy is a significant setback, as the previous administration allocated $1.7 million for such procurements and now this commitment is not being fulfilled. Several NGOs expressed concern about the government position. For example, the Bureau of Food and Drugs (BFAD) delisted emergency contraception, claiming that it has abortifacient effects. No one in the Philippines' reproductive health NGO community was notified of the order and it is said to have had a chilling effect, underscoring the secrecy around BFAD decisions.

Although the government is unlikely to procure contraceptives, most sources believe that it wants contraceptive donations to continue. In the event of a phase-out by USAID, most observers believe that the government will make a concerted effort to find a replacement donor.

POPCOM has spearheaded the Contraceptive Interdependence Initiative (CII), an effort to address contraceptive security concerns arising from a possible phase-out of donated contraceptives from USAID. CII task force members include representatives from the line agencies with an interest in population issues, NGOs representatives (including advocacy and service delivery NGOs), and CAs. It appears that private sector representation has been limited to one representative from Schering, who has since left the Philippines. CII has faced changes in membership that disrupted the continuity of participation, because of the political transition last spring. After a long hiatus, meetings recently resumed.

The CII position supports continued donations of contraceptives, but also strongly encourages a greater role for NGOs, the commercial sector, and local government units. The POLICY project completed a market segmentation analysis in 1998, which was disseminated and discussed within the CII. CII supports a market segmentation approach to rationalize the roles of different providers.

Devolution has placed a significant burden on local governments; their ability to meet the public health needs of their citizens varies considerably. It appears that local government commitment to meeting reproductive health needs also varies. Any attempt to ensure national contraceptive security for products and services will need to look more closely at local level capacity and commitment.

Donors

USAID has long been the provider of donated contraceptives to the DOH. Concerns about sustainability and the impact of free products on the commercial sector have led to a consideration of a phase-out of donated products to the public sector. KFW funds products for DKT and supports a subsidized social marketing approach.

NGOs

The Philippines has a well-organized NGO community that has formed a reproductive health advocacy network. Many members of the network are involved in the CII and are concerned about contraceptive security. NGOs can be an important ally in taking a comprehensive approach to contraceptive security.

Commercial manufacturers and private providers

Commercial contraceptive manufacturers vary in their interest in pursuing contraceptives as a business opportunity. A number are satisfied with their current clientele, growth, and income, and are less interested in generating demand among other market segments. Other manufacturers are more intrigued by growing demand and the potential impact of a USAID phase-out. Many are concerned about visible activities that risk raising controversy with the church. For private providers (such as doctors and midwives) family planning may be part of their practice, but not usually the majority. There is awareness about potential opportunities

created by changes to PhilHealth benefits and beneficiaries, but less recognition of any potential opportunities that would be created by a USAID phase-out.

Business community

Perhaps due to the influence of the Church, there are many conservative individuals in influential positions in the business community. Leadership in many health-related companies (including pharmaceutical manufacturers, importers and retailers, and private health clinics) do not support family planning. In many cases, their enterprises do not permit or promote modern family planning. It is the norm for companies to take a low-profile approach to sensitive issues like family planning, because of these conservative attitudes and a desire to avoid controversy

Nevertheless, there are a number of business leaders who express concern about the impact of population growth on the economy. There have been a few initiatives to address these issues with key business leaders. While the business sector is important in the Philippines, it remains to be seen whether a general concern about rapid population growth could be mobilized into actions that support changing attitudes about or expanding access to family planning.

B. Market segmentation

Market segmentation is an approach to the provision of contraceptives and a type of analysis. "Ideally, an effective market segmentation approach permits the public sector to focus its services on those clients who are truly in need, while at the same time stimulating private sector to meet the growing demand of those who are able to pay."[26] As a type of analysis, market segmentation divides a market into homogenous segments, such that clients in a given segment are likely to respond similarly to marketing or service delivery efforts. Identifying the market segments should clarify who truly needs public sector provision and who can be shifted to purchase from the private sector.

The POLICY project market segmentation analysis finds that more than 40 percent of middle and high-income users obtain their family planning products and services from the public sector. This data demonstrates the potential for shifting users. Further analysis is needed to determine:

- *What users have the potential to be shifted from public to private sector?* This question needs to look more closely at method choice and urban versus rural location.

- *What is the potential to attract new users?* These users would be women with characteristics similar to modern method users who are using traditional methods or not using contraception at all.

- *Who are the users that will continue to need public sector services?* In addition to income, the analysis needs to look more closely at method choice, as private sector services for IUD insertions may not be widely available. Furthermore, additional analysis of income levels is warranted. Using the rule of thumb that clients can afford to pay 1 percent of their income for temporary methods, several of the low-income clients groups should be able to afford the socially marketed products or even the locally manufactured OCs.

[26] Alano, et al, *Family Planning Use in the Philippines: Market Segmentation Study* (POLICY Project, 1998)

A description of the needy population, which considers income, method choice and urban/rural location, will facilitate the development of a strategy to ensure availability of products for all clients. This type of information would assist USAID in developing a phase-out strategy.

A description of the potential markets for private sector products and services is useful information for commercial manufacturers and private providers. Information on their potential market assists them to make decisions about how to attract new clients.

At this point, a market segmentation approach is still theoretical. Concerns about an impending phase-out may provide an impetus, but implementation will require concerted efforts by a broad array of stakeholders. Better information, as suggested above, can facilitate decisions and encourage action. Dialogue among the parties can help reach consensus on issues such as the complementary roles for different providers. The DOH and LGUs have a key role to play, as they must agree that their limited resources should be targeted to the poor and hard to reach. Furthermore, they must enact the policies and procedures to implement a targeted approach. Advocacy NGOs can help encourage government to make and implement the difficult policy decisions. Social marketing organizations or service delivery NGOs can provide products and services for population segments with limited ability to pay but no access to providers. Finally, the private sector, including manufacturers and providers, needs to clarify its willingness to participate in a market segmentation strategy. The private sector can create demand and expand provision, especially of products and services targeted to new market segments.

C. Analysis of Policy Initiatives

USAID and its CAs in the Philippines have made considerable efforts to identify and pursue a wide range of policy issues. A number of the policy issues identified would affect the commercial sector. CMS conducted a preliminary assessment of the policy issues in an attempt to identify those initiatives most likely to encourage – or discourage – private sector growth. The analysis was based primarily on the proceedings of the two Policy Issues Workshops, held in June and September of 2001, supplemented by further questions and discussions in the Philippines. The analysis proposes two sets of criteria, one for policies that encourage greater private sector provision and a second for those that discourage the private sector. The sections below explain the criteria. Appendix 4 examines those policy initiatives likely to affect the private sector according to the criteria. The policy initiatives that appear to be most favorable to the private sector are presented below.

Policies that foster greater private sector provision

These criteria should be considered illustrative of the types of policy reforms that would affect and encourage the private sector to increase their provision of family planning.

Avoid subsidized competition. Free contraceptives in the public sector and highly subsidized products provided by DKT appear to satisfy most of the demand from middle and lower income clients. The commercial sector focuses on the remaining, high-income clients. The private sector would be encouraged by policies that level the playing field between private providers and public sector/social marketing by reducing the level of subsidies, decreasing the quantity of subsidized products, targeting of subsidies to the needy, or including the private sector as providers eligible for reimbursement of services covered by the national health insurance program.

Increase financing for private sector provision. Financing for products and services in the private sector comes primarily from households but also from third-party payers, such as social health insurance, private health insurers, or companies that cover services for their employees. Expanding these financing sources would encourage the private sector.

Expand private distribution options. Except for condoms, all contraceptives are considered ethical products, which require a prescription and limits who can dispense. One exception is that trained midwives are allowed to dispense contraceptives. Permitting OCs to be distributed over-the-counter or allowing more private providers to dispense products could increase private provision of family planning.

Create demand for private sector providers. Policies that direct clients to the private sector, such as PhilHealth accreditation of private providers or referrals to private providers, would increase demand in the private sector.

Policies that discourage greater private sector provision

These criteria should be considered illustrative of reforms that would not encourage – and might even discourage – the private sector to increase its provision of family planning.

Distort the market. Policies that support the untargeted provision of free and subsidized products and services, especially when positioned to compete with the commercial sector, discourage private sector expansion.

Prescribe actions or demand compliance. The commercial sector is profit-motivated. Policies that prescribe specific behaviors by the private sector, especially actions that would not be considered to be within their business interests, are likely to be met with low compliance by the private sector. Further, these types of initiatives may be counter to engaging the private sector as a collaborator.

Incite controversy. Family planning is a sensitive political issue in the Philippines. Some individuals, including providers and clients, oppose modern methods of family planning because of their personal religious beliefs. Policies that single out family planning for special treatment, require the provision of family planning by providers, or otherwise put family planning in the limelight threaten to incite controversy and a backlash against those policies. The private sector does not want to be involved with a political controversy.

Work at cross-purposes. Although increasing private provision of family planning is not the only concern of USAID and CA policy efforts, other policy initiatives may adversely affect the private sector. For example, if the GoP does use budgeted resources and procure contraceptives, the products will likely be provided free by the public sector. This support will continue to distort the market.

Promising policy initiatives

Based on the criteria described above and the analysis in Appendix 4, the following policy initiatives hold promise for expanding private sector provision.

Oral contraceptives provided over the counter (OTC). The original proposal was for family planning commodities to be provided OTC, but CMS suggests that the policy proposal is more appropriately limited to oral contraceptives (OCs). In reality, OCs are already accessible OTC. Clients obtain their pills directly from the pharmacy without a prescription or, after using their initial prescriptions, they obtain refills without another prescription. Therefore, switching OCs to OTC status may not increase private sector provision dramatically. Nevertheless, there is another important reason to argue for the change in status: as they are classified as ethical products, commercial manufacturers are prohibited from engaging in brand advertising for their pills. Switching to OTC would allow manufacturers to advertise, generating demand in the private sector. Manufacturers will likely continue to take a cautious approach to demand generation activities.

Injectables and IUDs are different. Quality provision of these products requires good counseling and trained service delivery to manage side effects and discourage discontinuity. Transferring these family planning products to OTC status could undermine critical quality considerations.

Policies relating to PhilHealth initiatives. Several initiatives relating to PhilHealth were discussed in the preceding section on Health Finance. Some of the specific policies worth mentioning as promising policy initiatives include:

- PhilHealth expansion of benefits to include FP/MCH/RH services;
- PhilHealth expansion of beneficiaries to include informal sector and indigents; and
- Identifying alternative financing for services not covered by PhilHealth.

Also, it should be noted that there are duties on contraceptives, but an exemption process exists. While the process is cumbersome and needs to be renewed annually, the manufacturers appear to be gaining exemptions. Removing the duties on contraceptives, streamlining the exemption process, or seeking exemptions from value added tax (VAT) are valid policy initiatives. As the duties and the VAT are not excessive and exemptions for the duty are available, these policy changes are unlikely to have any significant effect on prices or supply. At best, these policy reforms may be interpreted as a sign of goodwill toward the commercial sector.

D. Conclusions

There are a small number of important policy initiatives that will encourage greater private provision of family planning. In addition, a market segmentation approach could increase the potential market of the private sector and -- especially in the event of a phase-out of USAID donations – help ensure contraceptive security. To help implement these policy changes, however, one element is notably absent – a role for the private sector in policy dialogue and problem solving. Most of the discussion and initiatives to increase the participation of the private sector so far have occurred without the full and active participation of private sector representatives, including commercial contraceptive manufacturers and private service providers.

To better participate in policy dialogue and problem solving, the private sector needs:

Voice. Private sector representatives need to talk among themselves and develop positions on issues that affect them, such as policy initiatives, phase-out of donations, or PhilHealth reforms. They need to be the ones to explain how proposed interventions would affect them and how they might react.

Information. The private sector needs better information for decisions. It may come from dialogue with donors or government or from studies conducted by NGOs, research organizations, or CAs. An organization of private sector representatives might even commission its own research.

Mechanism for collaboration. Representatives from the private sector should be considered partners in addressing the challenges of contraceptive security. As such, the private sector parties need a mechanism to collaborate among themselves, as well as with NGOs, government, donors, and other interested stakeholders.

E. Suggested Strategies

These findings and conclusions point to the following recommendations to improve the policy environment for private provision of family planning.

1. Facilitate the establishment of a private sector-led coalition for reproductive health.

Contraceptive security is likely to be a challenge in the near future in the Philippines because of the heavy reliance on donated contraceptives and increases in contraceptive demand. The private sector has the potential to be an important part of the solution. Engaging the private sector implies that the private sector is a partner, or key stakeholder, for contraceptive security. As such, the private sector needs to have a voice, obtain information, and collaborate with other contraceptive security partners.

CMS recommends that USAID support the establishment of a coalition for reproductive health, in which the private sector has a leadership role. The rationale for this coalition is that the private sector needs its own organization to exercise leadership, just as NGOs are organized into the Reproductive Health (RH) Advocacy Network. This organization would become the private sector counterpart to the government-sponsored CII. Furthermore, due to differences in working styles and time pressures, the private sector may be less inclined to participate in organizations or initiatives that are perceived as being more talk than action. This coalition would allow commercial manufacturer and distributors and private provider representatives to set an agenda of issues directly of interest to them and engage with other actors – RH Advocacy Network, CII, donors, CAs, and the business community.

CMS recommends that the private sector representatives make primary decisions regarding the organization of the coalition and its agenda in conjunction with USAID support. Nevertheless, illustrative activities might include:

- Sharing information – although not proprietary information – among themselves and with other partners;
- Commissioning research, such as determining willingness and ability to pay for family planning among current DOH clients;
- Collaborating, such as for demand creation;
- Strategizing with partners regarding challenges, such as contraceptive security;
- Reacting to proposals, such as for donor phase-outs or social marketing; and
- Advocating for policy reform.

2. Develop contraceptive phase-out plan and discuss with the private sector.

Lack of information is one of the key constraints to the private sector developing plans that might increase investment in contraceptive manufacturing, distribution, provision, etc.. While the possibility of USAID phasing out its contraceptive donation is well known and stirs speculation, the uncertainty discourages action. USAID is not the only cause of uncertainty. Responses to a USAID phase-out by the GoP and other donors, is not certain either.

As the analysis on contraceptives products demonstrates, the market in the Philippines is quite complex. CMS recommends that USAID, in collaboration with the private sector and other stakeholders for contraceptive security, develop a phase-out plan based on the markets for each method. A phase-out will threaten contraceptive security. Collaboration and consultation will enable USAID to better predict reactions from other stakeholders, so as to minimize the negative impacts of a phase-out.

3. Revisit the market segmentation analysis to determine impact of USAID phase-out.

The previous market segmentation analysis (Alano, et al, 1998) does not analyze adequately the impact of method choice and urban/rural location. Furthermore, there are contraceptive security questions that need to be answered, such as what users can be shifted to the private sector and who will continue to need public sector services. CMS recommends further analysis to better describe existing market segments. This information is crucial for an informed debate on contraceptive security and for a USAID phase-out.

4. Develop experience with pilot tests that shift public sector clients to the private sector.

Expanding the number of clients who procure contraceptive products and services from the private sector requires generating demand among non-users and referring them to the private sector, shifting users from the public to the private sector, or both. As public sector family planning products are offered for free, many clients choose to go to the public sector, including clients who can afford to pay for services. There are a number of mechanisms that can be used to shift users from public to private facilities. These methods include imposing user fees or voluntary donations in the public sector, instituting means testing that provides subsidies only to clients identified as needy, targeting public subsidies based on clinic location or other criteria. The assessment team understands that there are some pilot efforts underway by MSH and the POLICY project to explore such mechanisms.

CMS encourages pursuing such pilot tests to explore a range of mechanisms in a number of different LGUs. These experiments should be documented and analyzed to determine effectiveness, administrative feasibility, and political palatability. If successful pilots are developed, documented results should be advocated to the GoP and other LGUs for adaptation or replication. Results should also be shared with private sector partners to demonstrate the potential to shift public sector clients to the private sector.

5. Review policy initiatives and pursue those that foster private sector provision.

The list of policy initiatives should be reviewed to determine which may be discouraging to the private sector or unlikely to harness the capacity of the private sector. For policies that would not be conducive to the private sector, abandon initiatives unless they have other important expected outcomes. Policy and advocacy efforts should be focused on policies that clearly facilitate the expansion of private sector provision.

IX. SUMMARY OF SUGGESTED STRATEGIES

The strategies suggested throughout this report can be organized into two clusters. The first group of recommendations is intended to **increase private provision of family planning**. The second set recognizes that, in the event of a phase-out of commodities by USAID, an increase in the provision of family planning by the private sector will not be sufficient to **ensure contraceptive security**. Therefore, the second cluster recommends additional actions to help achieve contraceptive security.

These recommendations include new initiatives and suggestions regarding ongoing programs. The recommendations are ranked by priority to reflect the team's view of their potential impact and include an estimated time frame for implementation:

- Short term – less than six months
- Mid to long term – six months to two years
- Long term – longer than two years

CMS is well qualified to implement the new initiatives and assist with refocusing existing activities. As USAID's flagship project on the private sector in the PHN office, CMS encompasses a broad range of expertise related to the private sector, including policy reform and advocacy, social marketing, partnerships with pharmaceutical companies, health financing, NGO sustainability, provider networks, and service delivery. The uniqueness of CMS is the ability to work across these areas of technical focus to develop and implement programs that holistically and strategically support private sector goals. Specifically for contraceptive security, USAID/Washington has anointed CMS as the primary project to articulate and foster the contribution of the private sector to contraceptive security.

A. Recommendations to increase private provision of family planning

Increasing provision of family planning in the private sector requires increasing the demand for contraception *in the private sector* and increasing the supply. Other actions can improve the environment in which private provision takes place.

Increasing Demand

HIGH PRIORITY

1. Support demand creation activities that increase demand for private sector products and services.

Strategies to develop demand for contraceptives are typically developed by the DOH or NGOs, which direct users away from the private (commercial) sector. Developing demand creation programs with commercial sector partners (international and domestic) will ensure that new users are more likely to seek products and services in the private sector than in the public or subsidized one.

Possible interventions: CMS can replicate the approach being used in its current India OC campaign that includes partnerships with manufacturers in India, focused demand creation activities (such as mass media campaigns and provider detailing), and a carefully targeted public relations campaign. Also, CMS can coordinate and link with other awareness change campaigns that may be ongoing. In addition, CMS can help bring the private sector in as a stakeholder in other USAID-funded communication activities.

Time frame: Long term.

2. Support PhilHealth plans that expand the enrolled population and expand the coverage of family planning services, especially by private sector providers.

Changes in PhilHealth policy (such as expanded family planning benefits and adding coverage for informal sector workers and indigents) can encourage more private sector provision of family planning. Monitoring the changes can ensure that reforms are encouraging enrollees to seek private sector services and encouraging private providers to offer the services.

Proposed intervention: CMS can assess ongoing reforms at PhilHealth to determine how implementation is currently affecting – and is likely to affect in the future —private sector provision of services. If warranted, CMS can provide TA to strengthen implementation for the private sector.

Time frame: Mid to long term

3. Explore partnering with Pharmacia to increase demand for injectables in the private sector.

Pharmacia is eager to form a partnership that will build demand for injectables through a consumer-directed communication campaign and enhanced provider retailing/detailing activities. There is a strong possibility that the company might consider identifying a partner within the coming months. Now is a good time for USAID to influence the sustainable development of this method in the Philippines.

Proposed intervention: CMS can work with Pharmacia to develop an intervention focusing on communication and detailing. In addition, CMS can leverage existing relations between Pharmacia and midwives to develop a quasi-network of providers who provide affordable and reliable services related to injectables.

Time frame: Mid to long term

4. Assess potential contribution of more extensive medical detailing campaign (beyond just injectables) that would be directed at best placed pharmacists and private providers.

In the Philippines, there are inordinately high rates of discontinuation with OCs, injectables, and IUDs. Other than users' desire to become pregnant, DHS data shows this discontinuation is overwhelmingly attributable to users' fears of side effects and health concerns. Often we find that most, if not all of these fears, are unwarranted. The continuing existence though of such perceptions in a program with such a long history, suggests providers and pharmacists could do a better job of addressing these concerns. One of the most cost effective ways that has been employed to reach these providers is with a medical detailing approach.

Proposed Intervention: As part of a larger demand generation campaign (see recommendation no. 1), or independently, CMS can help orchestrate a medical detailing campaign to key private providers and pharmacists that would involve partnerships with providers' professional associations and pharmaceutical companies.

Time frame: Long term

MEDIUM PRIORITY

5. Refocus employer-based strategies. Approach labor organizations to discuss potential collaboration on health and family planning initiatives.

In areas where providers are already available, attempting to create new service facilities at work sites can not only be a redundant and wasteful effort, it may also compete with existing private sector providers. USAID should support analysis to determine the extent of such redundancy. If considerable, USAID should refocus this program effort on:

a) providing employees with information and referrals on reproductive health;

b) working with employers to bridge current gaps in coverage of key MCH/FP services; and

c) attempting to achieve the insurance enrollment goals of the country.

Because formal sector employees generally have a greater ability to purchase contraceptive products than others, it may want to reconsider the current practice of providing these worksite programs with USAID-donated commodities. As compliance with this legislation has been mixed, a more cost-effective approach may encourage a greater number of employers to participate. Some labor organizations are already active in this program area and there may be areas for greater results where similar efforts with management and labor can be brought together.

Proposed Intervention: CMS would undertake analysis to better determine work force with potential access via convenient, insurance-financed sources, meet with key organizations involved, then provide USAID with a more detailed proposal describing feasibility and potential contribution.

Time frame: Short term (for initial analysis, with the possibility for ongoing partnership albeit reduced LOE from present, with local groups)

Increasing Supply

HIGH PRIORITY

6. Document impact and lessons learned from the Midwives Clinic Network project and explore mechanisms for working with private midwives to expand their provision of family planning products and services to low and middle-income clients.

Midwives are comparatively more accessible to lower income women, are typically supportive of family planning, and are one of the more available types of medical provider in more rural areas. For these reasons they are attractive as partners to development groups as well as contraceptive manufacturers who want to increase family planning provision. Given the considerable investment made to date and the apparent success of the midwives clinic network experiment, CMS recommends at a minimum that USAID support sufficient assessment and documentation of the outcomes and impact of that project. Depending on the assessment results, USAID should consider supporting the expansion of this effort to increase the availability and viability of private sector midwives.

Proposed Intervention: A local social/program research consulting group or team of consultants (alternatively hired through a group like POPTECH) can be contracted to perform the outcomes and impact assessment. If the Mission prefers, CMS can help design the research, and also manage the process. For the proposed expansion of the project, CMS recommends USAID continue with the same project management team that has been responsible for this project to date. Maintaining this organizational history and knowledge will be critical.

Time Frame: Short term (for assessment), and long term (if USAID decides to expand the effort).

7. USAID should track performance of Friendly Care clinics and its contributions to increased private sector capacity, versus other private providers' services, to determine Friendly Care's comparative contribution to overall private sector service supply and program goals.

Given USAID's investment in the Friendly Care clinic network, additional performance monitoring seems warranted. This monitoring should include what FP services other existing private providers may be providing. This will help USAID make a more informed decision regarding the use of its resources.

Proposed Intervention: USAID should assess the clinic network's comparative contribution by conducting market research that would determine the extent to which such service delivery already exists in the private sector, what additional contribution is being provided by this network (at present, and with realistic projections for the future), and at what cost to USAID.

Time frame: Short term

8. Conduct research on public-private utilization patterns.

In light of the interestingly high private sector provision of sterilization, CMS recommends analyzing current public-private contraceptive utilization patterns, looking method by method, and also by each type of key provider, to help identify factors that may be encouraging or discouraging clients' utilization of modern contraceptive services, and their choice of public versus private providers.

Proposed Intervention: CMS recommends it develop a research protocol for this work then contract with a local social/program research/consulting group for the research and analysis.

Time Frame: Short term (for conducting the information collection, additional primary research that may be needed, and analysis).

MEDIUM PRIORITY

9. Explore partnership opportunities and assess quality of local manufacturers of oral contraceptives. (Note: Priority may change based on results of quality/capacity assessment.)

Partnering with local companies and providing marketing and product development assistance can help these companies meet increased demand for affordable products. Ensuring quality is an essential element in expanding local capacity.

Proposed Intervention: CMS can arrange to have the quality of local OCs tested and develop a strategy to reposition *Micropil* on the market. TA may include repackaging the existing product so that it is more in line with its current price (especially compared to *Trust*). If needed, CMS can help identify sources of financing to increase capacity or product quality

Time frame: Mid to long term

10. Work with existing professional associations to promote family planning provision and quality standards.

Professional associations are powerful and respected. In the Philippines, three types of providers (and their associations) cover the vast majority of clinicians involved with family planning delivery – midwives, family physicians, and obstetricians and gynecologists. Collaborative efforts can involve work through existing mechanisms these associations already routinely use – member certification, continuing medical education units (CMEs), accreditation, and professional development training – to improve and increase the provision of family planning services.

Proposed Intervention: CMS can work with the professional organizations and possibly pharmaceutical organizations to develop proposals for collaboration.

Time Frame: Long term (actual implementation would be done on an annual cycle; to be conducted for three years)

Improving the environment for private sector provision

HIGH PRIORITY

11. Facilitate the establishment of a private sector-led coalition for reproductive health.

The private sector is more likely to take on a proactive role in family planning if it has a forum to discuss issues and develop common strategies with other stakeholders. Creating a coalition will also provide representation for the private sector for the purpose of communicating with the DOH, donors and other contraceptive security partners.

Proposed intervention: CMS would collaborate with private sector leaders to structure and launch the coalition and decide on an initial agenda, bringing in other stakeholders as appropriate.

Time frame: Short term

12. Review policy initiatives and pursue those that foster private sector provision.

Although well intended, some policy initiatives may have the effect of worsening the current public/private ratio of contraceptive supply. Review the list of policies that have a positive impact on private sector share (see Policy section of this report). Avoid pursuing policies that are at cross-purposes with private sector development strategy to ensure coherence across USAID programs.

Proposed intervention: CMS, or another CA, should further assess the policy initiatives to determine their likely impact on the commercial sector, and facilitate a discussion to identify priority initiatives.

Time frame: Mid to long term

MEDIUM PRIORITY

13. Assess PhilHealth's technical assistance needs (in select operational facets that will allow it to more rapidly expand its coverage).

PhilHealth has identified an interest in receiving TA with some very specific operational issues it is currently grappling with. As discussed in the body of this report, these are issues that affect the rate at which PhilHealth can expand its insurance coverage. We recommend USAID investigate the means now available for providing TA to PhilHealth, and determine if additional or different assistance is warranted.

Proposed Intervention: USAID should meet with PhilHealth to better ascertain any TA needs it has, and whether existing CA partners can facilitate provision of this TA. If desired, CMS can assist in the process of determining or facilitating provision of such additional TA.

Time frame: Mid to long term

B. Recommendations to ensure contraceptive security

Contraceptive security – when every person is able to choose, obtain and use quality contraceptives whenever she or he needs them – will be a challenge to ensure if USAID discontinues commodity donations. If free commodities are no longer available in the public sector, some women will switch to the private sector and be able to pay. This is the potential market for the private sector, both commercial and social marketing. There are other women, however, who cannot switch to the private sector because they cannot pay or do not have access to the desired products or services (e.g. they live in rural areas). A comprehensive strategy for contraceptive security needs to consider the availability of products and services for all clients.

HIGH PRIORITY

14.Develop and publicize contraceptive phase-out plan.

Developing and announcing a phase-out plan will put an end to speculation and help private sector stakeholders plan for possible increases in demand for commercial products. Planning and public-private cooperation can help minimize the negative impact of a donation phase-out by creating awareness of USAID policy, and providing a framework for public/private cooperation.

Proposed intervention: CMS could assist USAID to manage the process of developing a phase-out strategy, including conducting necessary research (see recommendation no. 17 below on market segmentation analysis), discussing the strategy with stakeholders (see recommendation no. 11 above for private sector-led coalition), and making decisions about alternative courses of action.

Time frame: Mid to long term

15. Assess DKT's capacity to absorb large increase in demand for low-price OCs and condoms.

DKT is a very important player in the contraceptive market. However, the NGO has experienced frequent stockouts in the past. If funding for commodities is likely to be insufficient in the near future, USAID may want to look into partnerships (see below) to ensure a safety net for current users of donated contraceptive products.

Proposed Intervention: CMS can work with DKT to assess its funding opportunities and quantify the level of demand it can realistically meet. Partnerships with other suppliers can be developed that will be complementary rather than at cross-purposes with DKT's strategy for the mid to long term.

Time frame: Short term (for assessment); followed by continued collaboration

16. Assess the capacity of local manufacturers to meet increases in demand.

A donation phase-out will threaten contraceptive security unless suitable alternatives (or plans to develop them) in the private sector are available. Partnerships with local manufacturers may ensure that current recipients of public-sector commodities will be able to find affordable products in the commercial sector.

Proposed intervention: Similar to proposed intervention as suggested in recommendation no. 9 above.

Time frame: Long term

17. Revisit the market segmentation analysis to determine the impact of phasing out USAID-donated contraceptives.

The market segmentation study done in 1998 needs to be updated or further analyzed to determine the extent of the population – rural and low income – likely to need public sector products to ensure their access to family planning. Additional analysis should also show, by method, the number of clients who would be a potential market for the private sector if products donations were phased out. This information will facilitate development of a safety net and encourage a private sector response.

Proposed intervention: CMS could further refine the market segmentation analysis to ensure that it provides necessary information to inform a phase-out strategy that adequately considers contraceptive security.

Time frame: Short term

18. Develop experience with pilot tests that shift clients from the public to the private sector.

Moving users from public to private facilities will increase private sector share of the contraceptive market and reduce dependence on free and subsidized products and services. USAID should pilot test and evaluate the effectiveness of mechanisms that shift users from public to private facilities.

Proposed intervention: CMS would compile information on existing pilots and determine whether the pilots and planned monitoring will provide a sufficiently broad range of experience. If needed, CMS would propose changes to existing pilots, new pilots, or expanded monitoring activities.

Time frame: Mid to long term (if developing new pilots); long term (for monitoring existing endeavors

LOW PRIORITY

19. Consider alternatives for ensuring a supply of IUDs.

IUDs represent a very small percentage of current USAID donations and are used by a limited number of women. However, donations should not be phased out until an affordable alternative exists for low-income people. Also, USAID may want to consider maintaining donations for long-term methods as long as affordable provider services are hard to find in the private sector. Otherwise, USAID should explore strategies to introduce IUDs in the private sector.

Proposed intervention: CMS can approach manufacturers and facilitate the reintroduction of IUDs in the private sector. The same activities that are proposed for injectables would be applicable for IUDs in case of a complete phase-out.

Time frame: Short term

APPENDIX 1. SCOPE OF WORK

A. Introduction

USAID/Philippines has requested CMS to conduct an assessment of the current environment for commercial sector family planning services and products, and make recommendations for how USAID might expand that sector's contribution to family planning service and product provision. The assessment team will consist of three CMS staff, plus one local Filipino to be identified by the Mission. The team will be in country for 2 weeks. This document attempts to summarize the evolving/expanding guidance that has been provided by the USAID Mission in Manila, as well as the team's understanding of its scope and activities. This document will be frequently updated as new information and contacts become available. The Mission has noted it intends to continue providing the GOP with contraceptive commodity supplies as presently done, for at least the next 2-3 years.

B. Scope of Work, Overview

The objective of this assessment is to identify viable ways to expand the commercial sector's provision of family planning (FP) commodities and services. However, this assessment should also consider those organizations which could technically be identified as not for profit, but which must operate competitively in a commercial market. (The Mission's Friendly Care Foundation was mentioned as an example of such organizations.) The assessment should not consider traditional NGO organizations, which are charitable in nature and cannot operate competitively in a commercial market. The Mission is asking CMS to: (a) look into ways of expanding the commercial sector's activities so that it better complements the current program efforts being provided by the public and private nonprofit sectors, and (b) recommend how the commercial sector might step in to replace or fill gaps in services previously provided by the public sector.

The viability of commercial sector health and family planning strategies depends in part on what the public sector is doing vis-à-vis service delivery and pricing (and how that in turn impacts on current and potential markets for products and services). For this, it will be necessary for us to devote some of our time to reviewing the public sector and its practices as part of this assessment. Typically though, any one sector's expansion is at least in part a function of events/activities in the other sectors. Hence, effort will be made to review and suggest actions/positions vis-à-vis the other sectors that complement commercial sector expansion.

Because of how family planning is dealt with by commercial sector companies and providers, at points in this assessment it will be necessary to consider the dynamics of the larger commercial health/medical care matrix, rather than looking at FP alone in isolation.

The Assessment Team will visit the Philippines from February 18 to March 1, 2002 to conduct the onsite portion of this assessment. CMS will conduct research and interviews in Washington prior to this visit as part of this assessment.

The Mission (in its initial correspondence) has identified several specific strategies it believes may offer promise which it would like the team to assess and comment on:

- Social marketing.
- With medical professional associations, strengthen FP in their required training, core competencies, and clinical norms/standards.
- Create voluntary quality/standards accreditation body for private clinics that would incorporate FP as a mandatory quality standard.
- Demedicalize FP/MCH services (and dispensing of select contraceptive products) to allow more cadres of health professionals to provide services.
- "Declassify" OCs/injectables to OTC status in order to increase access.
- Strengthen laws requiring businesses (200+ employees) to provide FP/MCH services.

The assessment's "product" will consist of an analysis of the current Philippine commercial family planning sector, as well as the public and private nonprofit sectors AS THEY MAY IMPACT on the commercial sector. The assessment will identify constraining factors, needs and opportunities for expanding the commercial sector's provision of family planning services and products, as well as strategies USAID might pursue to help achieve such expansion. Where possible, the team will attempt to estimate the costs and types of investments needed as well as the time frames needed to pursue and achieve the various strategies recommended. USAID/Manila has requested the report be entitled, "Prioritized Actions for USAID's Private Sector Family Planning Programs in the Philippines."

This assessment will prioritize suggested actions into several categories. Examples of these categories include actions that:

- are most easily achieved;
- will have the greatest impact in the next two to four years;
- for which there will be the greatest resistance; and
- are most recommended by the major sectors/interest groups interviewed.

This assessment may be used by the Mission to guide its future program approaches. At the conclusion of the two weeks in country, the team will brief the Mission of its impressions and findings in an oral presentation. It will then provide the Mission with a full draft of its assessment report within a month of departing the country, and encourage the Mission for comments on this draft. CMS will then have a final version of the report back to the Mission within two weeks of receiving any comments the Mission may care to provide.

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APPENDIX 4. PRELIMINARY ANALYSIS OF SELECT POLICY PROPOSALS

Select policy proposals	Characteristics of policies that foster greater private sector activity				Characteristics of policies that do not foster greater private sector activity				Comments
	Reduces subsidized competition	Increases financing for private sector provision	Expands private distribution options	Creates demand for private sector provision	Distorts the market	Prescribe actions or demands compliance	Incites controversy	Works at cross-purposes	
Company clinics provide preventative health services		If companies contract with private clinics to provide services, then it could increase the financing, distribution options, and demand in the private sector.			Employees should have an ability to pay. Free FP discourages their use of private sector.	Compliance with existing law is low.	Requiring the provision of FP is sensitive.	If products are provided free, it works against efforts to reposition FP as a mainstream health product valuable enough to pay for.	
Health companies build and operate community clinics offering preventative services			Would expand private distribution.			Compliance unlikely.			Clinics unlikely to be profitable, so companies have no incentive.
Private practitioners offer FP services in their clinics			Would expand private distribution.			If expectation is that FP provisions is mandatory, than compliance will be difficult.	Because of personal beliefs, requiring FP provision may be controversial.		Training and quality standards should not present a problem, but mandatory provision may.

Select policy proposals	**Characteristics of policies that foster greater private sector activity**				**Characteristics of policies that do not foster greater private sector activity**				Comments
	Reduces subsidized competition	Increases financing for private sector provision	Expands private distribution options	Creates demand for private sector provision	Distorts the market	Prescribe actions or demands compliance	Incites controversy	Works at cross-purposes	
Private clinics dedicated to adolescent and indigent market			Would expand private distribution.			Compliance unlikely.			Clinics unlikely to be profitable, so companies have no incentive.
FP commodities provided over-the-counter			Would expand private distribution.	Would allow brand advertising, which is prohibited for ethical products					Need to explore likely impact on prices.
Train non-health professionals and allow them to provide FP services				Could increase demand if they provide information and counseling (not products) and refer to the private sector	If they provide free or subsidized products without targeting needy populations, it would distort the market.				Unclear that there is a shortage of trained personnel. May create quality issues unless just provide information and referral.

Select policy proposals	**Characteristics of policies that foster greater private sector activity**				**Characteristics of policies that do not foster greater private sector activity**				Comments
	Reduces subsidized competition	Increases financing for private sector provision	Expands private distribution options	Creates demand for private sector provision	Distorts the market	Prescribe actions or demands compliance	Incites controversy	Works at cross-purposes	
Parallel importation of contraceptives			Would expand availability of commercial products.		Would undermine efforts of local manufacturers and distributers to develop a commmercial market for lower priced products.			Parallel important would work against developing partnerships and expanding the role of existing international and domestic contraceptive manufacturers	
PhilHealth expansion of benefits to include FP/MCH/RH services	If clients have equal choice between public and private sector providers	If private sector are accredited providers	Could encourage private sector to offer or promote covered services	By leveling the playing field between public and private			Coverage of family planning services by PhilHealth may be controversial. It may be avoided by packaging FP with the other services and not singling it out for special attention		PhilHealth moving to cover outpatient sterilizations and IUD insertions. Injections could be covered under MCH package. Pills or condoms unlikely to be covered.

Select policy proposals	**Characteristics of policies that foster greater private sector activity**				**Characteristics of policies that do not foster greater private sector activity**				Comments
	Reduces subsidized competition	Increases financing for private sector provision	Expands private distribution options	Creates demand for private sector provision	Distorts the market	Prescribe actions or demands compliance	Incites controversy	Works at cross-purposes	
PhilHealth expansion of beneficiaries to include informal sector and indigents	If clients have equal choice between public and private sector providers	If private sector are accredited providers	Could encourage private sector to offer or promote covered services or to serve clients not previously considered their target audience.	By leveling the playing field between public and private					If costs are not fully covered by PhilHealth, will these enrollees seek private sector services?
Increase budget appropriation for FP/RH/MCH/HIV-AIDS/STD/ID					Products and services provided by the public sector will continue to distort the market if they remain free and untargeted.		Focusing on increasing allocations for family planning may be sensitive, even if it is bundled with other preventative services.	Given government's limited resources, does the budget for these services compete with resources for indigent coverage?	Perhaps it is more efficient to advocate for resources for indigent coverage and increases in the covered services.

Select policy proposals	**Characteristics of policies that foster greater private sector activity**				**Characteristics of policies that do not foster greater private sector activity**				Comments
	Reduces subsidized competition	Increases financing for private sector provision	Expands private distribution options	Creates demand for private sector provision	Distorts the market	Prescribe actions or demands compliance	Incites controversy	Works at cross-purposes	
Identify alternative financing for services not covered by PhilHealth	If financing can be provided for services rendered by private providers.	If private sector is included as service providers	Could encourage private sector to offer or promote covered services	By leveling the playing field between public and private					For contracep-tives, this is primarily an issue for indigents, as other beneficiaries should have some ability to pay for contracep-tives. One suggestion is to work through PhilHealth and explore supplemental insurance for indigents that covers FP and essential drugs.